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ABSTRACT

The book presents information on effective counseling with deaf people by discussing issues that confront counselors and administrators involved in providing counseling services to deaf people. A basic assumption of the book is that deaf people of all ages have been frequently denied counseling services due to communication problems between counselor and deaf client. Examined first by Boyce R. Williams and Allen E. Sussman are the psychological and social ramifications of deafness in the individual's personal, social, and vocational adjustment and development. Then McCay Vernon points out the current status of counseling with deaf people. In their analysis of principles of counseling with deaf people, C.H. Patterson and Larry G. Stewart offer excerpts from four different counseling sessions with four different deaf clients in order to demonstrate successful communication and counseling. Next, Richard W. Thoreson and Norman L. Tully explain the role and functi ns of the counselor with deaf people. The last discussion, by John F. McGowan and Geno M. Vescovi, is concerned with selection, education, and training of rehabilitation counselors in general and counselors of the deaf in particular. (CB)

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Counseling with Deaf People

Edited by Allen E. Sussman and Larry G. Stewart

DEAFNESS RESEARCH & TRAINING CENTER

New York University School of Education

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Deafness Research and Training Center
New York University School of Education
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Preface

During the past decade there has been increasing interest in the potential contributions of counseling and guidance with deaf people in school settings, community agencies, mental health clinics, and rehabilitation agencies and facilities. This interest is perhaps most clearly reflected in the growing numbers of counselors with deaf people employed in college programs, in State Vocational Rehabilitation agencies, and in various other settings, as well as in the slowly increasing number of university graduate-level training programs offering specialization in counseling with deaf people. Clearly, the field of deafness education and rehabilitation is beginning to appreciate the role the counselor can play in efforts to provide deaf people with the values, attitudes, knowledge, and skills they must have if they are to meet the challenges they face in their development and adjustment in today's rapidly changing world.

While those in the field of counseling with deaf people may feel justifiable pride in the progress made in recent years, future progress depends upon critical self-examination and vigorous attempts to strengthen areas of weakness and to continue to build upon strong areas. Without this continuing self-examination and attempts to further our knowledge in theoretical and applied aspects of our work, our advances will be nullified in the face of dynamic changes in deaf people and the world in which they live.

This book is intended to sharpen the focus of counseling with deaf people by presenting discussions of the major issues that confront counselors and administrators of programs that are either providing or considering providing counseling services to deaf people. Deaf people of all ages generally have been denied access to proper counseling services primarily due to the problems of communication between the counselor and the deaf client. General counseling programs have been unable to serve deaf people properly due to this problem, and, since there are relatively few deaf people in most areas of the country, it has not been possible to develop special programs for them as rapidly as needed. For this reason comparatively little attention has been given to the many theoretical and applied considerations that are basic to the growth and development of the profession of counseling deaf people.

For example, it would be reasonable for any general counselor or program administrator to ask the following questions with respect to counseling deaf people: (1) Are there special problems faced by deaf people that require specialized counseling assistance? (2) Must a counselor with deaf people learn special modes of communicating with his deaf clients? (3) Can the methods and techniques of counseling used with normally hearing people be used with deaf people? (4) What general and special training must a counselor have before he can work effectively with deaf people, and where can this training be obtained? (5) What research has been done in the area of counseling deaf people?

These questions are of relevance not only to professionals not acquainted with deafness but also to students who are preparing to become counselors with deaf people, as well as counselors actively engaged in counseling work with deaf people. The reason? At the present time there are no books devoted to providing answers to these questions! In fact some of these questions are considered in print for the first time in this book, and for this reason it is hoped that this book will be used as a text by university training programs and as a basic reference by practicing counselors with deaf people.

Four chapters in this book were co-authored by recognized authorities from the general field of counseling, and the second chapter was written by an authority from the field of counseling with deaf people. This approach was taken in order to provide a perspective of counseling with deaf people as it relates to the general field of counseling and also to bring together the current knowledge available from both areas. In some respects this is a radical departure from approaches used in the education and rehabilitation of deaf people, which for the most part have evolved without consideration of practices used with normally hearing people. We feel this new approach will add an interesting and valuable dimension to this book.

A better understanding of this book can be gleaned from the events surrounding its development. In 1969 and 1970, the New York University Deafness Research and Training Center sponsored a series of conferences on "A Task Force on Counseling Deaf People." The Task Force, which had in its membership the authors of the chapters in this book as well as former Center Director Dr. Edna S. Levine, Dr. Patricia Livingston of New York University, and, subsequently, present Director Dr. Jerome D. Schein, had the objective of developing means whereby the field of counseling with deaf people would be able to reach a level of professional development similar to that of the general field of counseling. During Task

Force discussions it was revealed that (1) there was very little about counseling with deaf people in the professional literature; (2) there was not a single textbook on counseling with deaf people; (3) there were no certification or training standards for counselors serving deaf people; (4) there is a widespread lack of understanding of what professional counseling consists of, as opposed to counseling done by an untrained person; and (5) it was difficult to plan a method to upgrade the field of counseling with deaf people in the absence of authoritative information concerning methods of counseling the deaf, problems in counseling with the deaf, and certification and training standards. Consequently, the decision was made to prepare a book covering these issues, since such a book would provide a *sound basis* for future activities in this particular area. This book is the final result.

It is the editors' conviction that the future development of counseling with deaf people will be determined by three factors. The first is the extent to which program administrators, consumer organizations composed of leaders of the deaf, and professional organizations such as the Professional Rehabilitation Workers with the Adult Deaf and the American Instructors of the Deaf recognize the need for and demand counselors for deaf people who are trained as counselors, have an understanding of the life problems and needs of deaf people, and can communicate with deaf people. The second factor concerns the extent to which universities and government-funding agencies cooperate in the establishment and operation of training programs designed to prepare counselors with deaf people of all ages, including young children and elderly people. The final factor concerns counselors with deaf people. They must become more actively involved in research designed to provide greater strength to counseling approaches used with deaf people; they must communicate better with other workers with deaf people and obtain their approval and support of counseling services; and, they must work through their professional and training standards.

This book contains information that can be used to upgrade the quality of counseling services for deaf people. It is not an end in itself, but a beginning. Hopefully this book will be the first of many on the subject of counseling the deaf.

The editors wish to thank the contributors to this book. The effort and time they put into the preparation of their chapters are gratefully acknowledged. Special thanks are due to Dr. Edna S. Levine, who supported the early work of the Task Force on Counseling Deaf People, and to Dr. Jerome D. Schein, whose strong support permitted early publication of this book.

Grateful acknowledgement is also made to the Social and Rehabilitation Service, United States Department of Health, Education, and Welfare, and to the School of Education, New York University, which together sponsor the work of the Deafness Research and Training Center. Without their support this book would not have been possible.

Allen E. Sussman
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New York City
September 1971

Introduction

The chapters in this book deal with what the editors view as the major areas of concern facing the professional discipline of counseling with deaf people. These areas are felt to be vital to a better understanding of the current status of the field, and any counselor or counselor-trainee who serves deaf people should have a thorough grasp of the many issues discussed in these chapters.

Chapter I, by Boyce R. Williams and Allen E. Sussman, discusses the psychological and social ramifications of deafness within the context of personal, social, and vocational development and adjustment of the deaf individual in today's world. The insights these authors bring to bear upon the subject represent knowledge that all counselors with deaf people should be expected to possess before they attempt to provide counseling to deaf clients.

Chapter II, by McCay Vernon, brings the current status of counseling with deaf people into sharp focus. Current counseling services for deaf people are described, present and future needs are analyzed, and suggestions for improving the field are made. This chapter is essential to an understanding of the strengths and weaknesses of current efforts at providing counseling services to deaf people.

Chapter III, by C. H. Patterson and Larry G. Stewart, presents an original discussion of principles and methods of counseling as they apply in counseling with deaf people. Patterson presents his views on what counseling is and what it is not, and Stewart relates these general principles of counseling to working with deaf people in the counseling relationship. This chapter should offer invaluable assistance to inexperienced counselors and counselors in training, as well as to practicing counselors, since it presents a discussion not only of the problems encountered in counseling deaf people but also approaches that can be used to overcome these problems.

Chapter IV, by Richard W. Thoreson and Norman L. Tully, is concerned with clarifying the role and functions of the counselor with deaf people. Thoreson analyzes current views of the general counselor's role and function, and presents compelling arguments in favor of requiring professional training for all counselors. Tully analyzes current views toward the

role and function of the counselor with deaf people and makes recommendations for application in the field. This chapter, in addition to providing a backdrop against which the role and function of the counselor with deaf people may be viewed with proper perspective, also stresses the necessity of proper role definition if counselors with deaf people are to achieve a proper professional identity.

Chapter V, by John F. McGowan and Geno M. Vescovi, is concerned with the selection, education, and training of rehabilitation counselors in general and counselors with deaf people in particular. McGowan reviews current theoretical and practical knowledge relating to the preparation of rehabilitation counselors and makes sound suggestions for application of this knowledge by counselor education programs. Vescovi reviews existing practices in the selection, education, and training of counselors with deaf people. Noting that the field has yet to establish standards, Vescovi presents recommendations for university training programs in the preparation of counselors with deaf people. The chapter should be useful not only to counselors and program administrators but also to professional organizations that are concerned with the certification of counselors with deaf people.

The reader will note that there is considerable overlap in content among the five chapters that comprise this book. However, it is felt that the ideas which recur from one chapter to another serve to underscore the underlying relationships between standards, training practices, and the actual practice of counseling with deaf people.

Finally, this book is basically concerned with rehabilitation counseling, as the reader will quickly discover. Yet, the many concepts that are discussed can be applied not only in rehabilitation settings but also in educational and mental health settings.

CHAPTER I

Social and Psychological Problems of Deaf People

BOYCE R. WILLIAMS
ALLEN E. SUSSMAN

Each of man's five senses is inevitably taken for granted until something goes wrong. He sees, hears, smells, tastes, and touches endlessly with no more reflection upon these complex processes than upon his breathing or his pulsating heart. The substantive difference is that, when he stops breathing or his heart surrenders, he has no more problems.

On the other hand, total or partial loss of function in any of the senses launches countless unique, often traumatic problems of adjustment or of compensation. Deterioration in vision or hearing triggers much more pervasive problems than losses in the other three senses, for they are the sharper and more critical conduits to man's miracle organ, his brain.

We are presently concerned only with malfunction in the sense of hearing and the social and psychological problems that stem from it. Furthermore, our primary focus is upon a relatively small portion of the millions of people with hearing impairment, those who are commonly labeled deaf.

Who Are the Deaf People?

The very common and erroneous practice of lumping along one continuum all people with hearing impairment confuses and obscures, with consequent loss of attention to the urgent special psychological and social needs of the small minority who are deaf. In actuality, the hearing-impaired comprise two distinct groups, the deaf and the hard of hearing. An indeterminate number straddle any sharp demarcation, because they

possess varying amounts of functional hearing that is invaluable in reducing the handicaps of the disability. Some of these in-between people may be called severely hard of hearing; others, deaf. The decisions rest primarily upon how they function socially and linguistically.

The hearing loss of deaf people is so severe that they receive communication almost entirely through their eyes. Simply put, they do not understand speech when their eyes are closed. Their hearing loss is usually irreversible. Medical intervention, such as drugs, surgery, hearing aids, is seldom effective. Training and other adjustment services are fundamental in reducing the handicapping aspects of this profound hearing impairment. Since most deaf persons have normal strength, mobility, and intelligence, they are often described as a non-hearing cross section of the general population with about the same range in other characteristics (Williams and Vernon, 1970).

The hard of hearing are those who have losses ranging from very slight to very severe. The critical factor in determining whether a person is hard of hearing or deaf is his means of speech reception. The hard-of-hearing person, as contrasted to an individual who is deaf, depends mainly upon his ears, with or without amplification. The hearing disablement of the hard-of-hearing person often yields substantially to the medical intervention of surgery, drugs, or hearing aids. As a consequence, the hard-of-hearing population differs psychologically and socially from the normally hearing population not at all or relatively slightly while deaf people are quite different.

The deaf are frequently estimated to include about 250,000 males and females (Lowell, 1964). A more accurate word at this time may be "guesstimate," since current measures are based upon samples that have not been widely accepted among demographers. Fortunately, a special census of the deaf population is now being conducted by the National Association of the Deaf. By 1974 confident judgments can be made about the size and other characteristics of the deaf population.

An added dimension to this general picture are deaf persons with other disabilities. They are often referred to as multiply handicapped deaf people and their increasing size has become of deep concern to educational, rehabilitation, and mental health specialists.

In recent years, for instance, epidemic prenatal rubella has caused an increasing number of deaf babies who have additional, secondary or superimposing disabilities that may compound learning and adjustment problems (Levine, 1951; Vernon, 1967b). As modern medical technology and skills are cutting down birth mortality rates and saving more and more children

from death, more and more have had to face life with residual multiple disabilities. Schools for deaf children are finding themselves with a burgeoning number of deaf children with brain syndrome disabilities such as mental retardation, aphasia, cerebral palsy—to cite a few examples. It is also not uncommon to find visual and orthopedic disabilities among deaf children. Emotional disturbances stemming from a combination of disabilities within a child is a common occurrence, thus placing an added burden on parents and professional persons endeavoring to cope with him. Sometimes the deaf child's disabilities are so severe that he cannot be accepted or kept in a school for deaf children. For lack of proper educational and treatment facilities he either is relegated to custodial institutionalization or kept at home (Vernon, 1969b). The multiply handicapped deaf individual represents a group that requires highly specialized educational programs, extensive and intensive periods of personal, social, and work adjustment training. He generally requires psychological and social services over and beyond that which is usually needed by the individual who has deafness as the only physical disability (Crammatte, 1968).

Meanwhile, it is helpful to be aware that, in an unselected group of 700 people, there is likely to be one deaf person. His deafness offers no visible clue that brings him to attention. It is usually only when he is spoken to or attempts to communicate that his disability surfaces. His communication problem is the source of the many handicaps that he has, the one great factor that accounts for his unique social and psychological problems.

Basic Circumstances

The chronology of onset of deafness is of great importance. Deafness from birth or before language and speech patterns are established pyramids almost all adjustment problems. Persons with experience of this kind are called prelingually deaf. They are clearly greatly disadvantaged compared to persons postlingually deafened at four year or later. Other factors being equal, the earlier the onset, the greater the handicaps.

"Stone" or total deafness is a rarity. In fact, most deaf people have some degree of sound perception. The amount and usefulness of residual hearing are important. They may be sufficient in some cases to aid in some aspects of speech production such as voice quality, rhythm, and so on. Others may be able to learn to distinguish as many as several hundred spoken words. While this strengthens their abilities in oral communication, it definitely does not make them hard-of-hearing people. Residual sound perception may also be sufficient to carry out a small share of the warning

function of hearing through alerting the deaf person in responding to environmental noise signals.

The sense of hearing is the channel to the brain for the greater part of human learning. The infinite flood of sound introduced to the infant's mind from countless environmental sources brings many cues that trigger reactions of acceptance or rejection. Sounds become good or bad, accordingly. The opening door, the hushed footstep, the rustle of clothing, the softly cooing voice mean mother and food, among other things, and pleasant or happy reactions. Learning is in process.

The sounds of nature, traffic, footfall, music, speech—ad infinitum—all contribute to man's apperceptive mass. Each combination of sounds stimulates an immediate positive or negative reaction or a train of thought relating to this accumulation of experience.

It is quite apparent that when ears are not functional, the human's experience base is grossly limited. Moreover, his environment of awareness sharply dwindles. He does not receive sound warnings of danger beyond his peripheral vision (Myklebust, 1960). He does not share in the emotional tempering of music, nor store knowledge from effortless conversation with normally hearing persons, nor benefit from regular church, public speakers, neighborhood interchange, drama. He may be very isolated in a milling crowd. The deprivations are pervasive.

Trite though the expression may be, this is in truth a hearing world. The deaf person is faced with multitudes of challenges over and above those with which all people must cope. He solves the simpler problems readily through reliance upon his unimpaired senses. Problems that are very complex and resistant may absorb all of his personal resources over many years of depth training, but all too often this is not available.

The Communication Problem

The communication problem of the deaf person is the most direct and far-reaching manifestation of his disability. It affects every aspect of his life. Other problem areas exist principally because of it. His degree of adjustment and achievement in all of his activities is primarily dependent on aspects of his communication skills. Likening the deaf individual to the hub of a wheel, the spokes represent his accomplishments, the rim symbolizes his skill in communication. Superior communication skills indicate a larger rim, thus longer spokes of achievement, thus a larger wheel with greater function.

Communication involves sending and receiving. The deaf person's problems stem from both functions. He is likely to have transmitting de-

ficiencies that are manifested in inferior language, written, spoken, manual. Moreover, he is usually deficient in his ability to comprehend language whether written, spoken or signed.

A few deaf people have fully intelligible speech and equally few read and write at superior levels. These are usually those deaf persons who have acquired speech and language before the onset of deafness, the postlingually deafened. Some deaf people at the other extreme have only natural gestures and pantomime. They are prelingually deaf persons who have had no effective school experience.

These are the extremes. Between them is the mass of deaf people who speak, write, and read poorly and yet are proficient with manual communication. Their written language is often ungrammatical and confusing to those unfamiliar with deafness and deaf people. Their speech is often difficult to understand due to deficiency in articulation and to their difficulty with verbal language.

These sorry facts are byproducts in part of the disability and in part of its inadequate remediation. They are not indicators of mental abnormality. Normal speech and normal hearing go together. This is true not only for speech development and imitation but also for speech maintenance. Without hearing, speech does not develop spontaneously in the deaf infant. The good speech skills of the newly deafened adolescent may deteriorate rapidly, if conservation measures are not adopted, simply because in losing his hearing he has lost the sense that monitors his speech production and instantly triggers remedial action. Likewise, correct language almost always is a byproduct of frequent and prolonged exposure to spoken language. Not to hear the voice is not to hear the spoken language (Levine, 1960). Since the deaf person is shut off from these normal learning patterns he does not acquire language or speech without special training procedures, which often do not begin until he is six years of age by which time a normally hearing child has an effective language structure and a large vocabulary.

Switzer and Williams (1967) discuss and analyze in some depth the implications with respect to the communication problem of traditional training practices. They state:

> Until very recently all deaf children have had their early formal training by what is known as 'the oral method.' It uses only speech, lipreading vibration, amplification, writing, and natural gestures in developing the child's speech and language powers simultaneously. It is slow and difficult for most and unsatisfactory for the overwhelming majority. The goal is a deaf individual able to assimilate, grow, and participate easily in normal communication situations.

Speech is a principal tool in the oral method. The visual cues that regular speech provides are often very fleeting and in many cases nonexistent. Much of the English language is not visible (Lowell, 1959). English is not an "outside" language such as Spanish, for example. Consequently, the deaf child often sees only a fraction of the stimulus and that very briefly. He is in constant struggle to comprehend what his normally hearing peer assimilates effortlessly. Thus, it is no wonder that relatively few deaf persons truly achieve the goals of the oral method, the ability to communicate fluently by speech and lipreading.

These oral specialized training techniques clearly have been unsuccessful for the overwhelming majority of deaf people (Vernon, 1970b). This failure is puzzling and frustrating in view of the normal intelligence of most of them. A byproduct is sharp differences in opinions and practices about rigid oral training among educators, other workers for the deaf, parents of deaf children, and deaf people themselves.

Increasing awareness of the communication plight of deaf persons and growing belief that it need not be so serious are quickening consciences in many directions. Knowledgeable professionals and consumers agree that reordering of educational goals for deaf children is urgent. Top priorities include earlier formal instruction for each deaf child and his family and broader methods than pure oralism from the beginning of formal training. Essential to the former is earlier discovery of the deaf child. This can be fostered by implementation of diagnostic procedures that may reveal hearing impairment in babies of one, two, and three years.

Upon discovery of deafness, the child's parents must become conscientious, full-fledged partners in an intensified program to inculcate at the earliest possible stage an awareness of symbols and their role (Mindel and Vernon, 1971). Many persons believe that the years from two to four are crucial for language acquisition. The instrument for involving parents may be the preschool for deaf children. It must reach into the homes much more intensively and earlier than it has. Great expansion of the relatively few ongoing preschools into a national network is urgent.

Broadening of training methods is axiomatic in light of the generally miserable results during the 150 years that deaf people have been formally trained in this country. An inclusive method that uses all possible cues simultaneously from the very beginning, that utilizes the deaf person's strengths, his normal intelligence and vision, is the only sound procedure until, and if, we have developed instruments that clearly identify children who will be able to grow to the limits of their native abilities unimpeded by the single oral method.

Happily, very recently a number of schools began following the leadership of the Maryland School for the Deaf by adopting policies of instructing all deaf students by what is called total communication. It includes use of all methods—speaking, writing, listening, fingerspelling, signing. No exclusions exist. When preschools, day schools, and residential schools everywhere adopt this humane, sensible policy, the communication problem of deaf people will be less severe and other problem areas correspondingly reduced.

Education of Deaf People in America

Compared to the rest of the world, American education of the deaf is quite advanced in terms of years of exposure and wide availability of opportunity. Most deaf children between 4 and 21 years of age secure more than 10 years of formal schooling in approximately 80 public and private coeducational residential institutions and over 400 day schools and classes all functioning largely at the elementary level (Gentile, 1970). At this point we can cease to be pleased.

The low-achievement level of the students of those programs is a tragically prominent characteristic of this very costly and difficult process. Important reasons are language deficiencies and late introduction to school. Many have entered school at six years of age with no language concepts, with little or no awareness of anything outside their immediate spheres, with lack of insight about much that is close at hand. Consequently, they are far behind the six-year-old normally hearing child who has a vocabulary of thousands of words, syntactical English, wide knowledege of his environment and its human and material interrelationships. The deaf child generally never catches up in reference to coping with usual school subjects although he may excel in vocational subjects, athletics, drama, art, and so on.

At 18 to 19 years of age many deaf youth terminate their formal education. A small number go on to Gallaudet College or its Model Secondary School, federally supported liberal arts schools for deaf students in Washington, D.C., to the National Technical Institute for the Deaf in Rochester, New York (also federally supported), to colleges for normally hearing students, or to the few newly established regional vocational and technical schools for deaf persons located in different parts of the country. The age-old pattern of severely restricted secondary and higher educational choices are clearly easing. Still, the majority do not complete the programs in the special elementary schools. Most of them depart as functional illiter-

ates, reading at fourth-grade achievement level or less and expressing themselves similarly (McClure, 1966).

Switzer and Williams (1967), recognizing that educators of the deaf are deeply concerned over the low returns on our considerable investment in deaf education, state:

> Their search for solutions is endless. Nevertheless, one too often finds resignation, or worse, the rationalization that deafness precludes real skill in communication. Thus we have too much acceptance of lower standards of performance, too low aspirations for deaf children compared to their normal peers. This insidious situation fosters and nurtures the paternalism which so frequently enmeshes deaf people as they seek to participate in and direct their own destinies.

It is approprate, at this point, to raise some questions. Is it not time to question seriously the narrowness and inflexibility of the educational procedures that have produced such a large proportion of deaf persons unable to communicate effectively by any means despite 10 to 15 years of schooling? Should not such severely handicapped children be taught by all means—speech, lipreading, vibration, amplification, writing, and manual language? The standard approach to the deaf child's mind sometimes appears to exploit weaknesses rather than use strengths such as his natural sign language. It seems self-evident that free use of all methods will more quickly create the vital language reservoir essential for effective expression. In other words, language should clearly supersede speech as the top-priority goal in education of the deaf. Strangely, in the education of the deaf, speech and language are synonymous in the minds of many teachers. Their professional training has not encouraged clear grasp that speech is only a vehicle for language. The servant passes for the master.

The unique role of parents of deaf children should be emphasized. Parents of deaf children who are the logical forces to rectify inadequacies play a transitory role. They are initially excited by the hope of oralism and accordingly are supportive of it and demanding. Later they are apprehensive as their child probably does not achieve as they dreamed. They may begin to learn signs and fingerspelling, which they may use haltingly to try to restore their child to the family circle. They may drift into the apathy of accepting a less than proper standard of performance for their deaf youngster. They may become aware of the proper priorities in the education of the deaf when their child is close to terminating his training and when their enthusiasm has dwindled in the face of relative failure. The field belongs to the younger parents and a new cycle begins. Very recently, however, many parents of deaf children have indicated a new awareness

of the educational and emotional needs of their children and are organizing for remediation.

What has been discussed previously concerns the typical deaf child with limited communication skills. We would be remiss, however, if we fail to mention the problems that are looming on the educational horizon for the more gifted deaf children. By comparison, they are the ones who possess good academic ability and have good to excellent speech and lip-reading skills. The present trend is to integrate these children into schools for the normally hearing from the elementary to the high school levels. The exodus of bright deaf children from special schools for deaf children, which started a few years ago as a trickle and which is now being carried on at an accelerated rate, may serve as a harbinger of what is yet to come.

To be sure, there are glowing reports of academic progress from educators and parents of these deaf children. However, if we were to probe them more deeply, we may often find things not "as advertised." We would also find that such educational integration, while being a boon for some deaf youngsters, may also be a bane for others. The latter group includes deaf youngsters who have difficulty in effecting satisfactory emotional and social adjustment to an environment that is geared to the world of sound. The lot of a deaf youngster making this transition is indeed a hard one. It has serious mental health ramifications.

The deaf youngster in a regular public school usually finds himself in an alien and threatening psychological environment. He is continually exposed to extremely stressful situations and often feels isolated, frustrated, and helpless. Children, as we know, can be cruel to handicapped children. The deaf youngster too often finds himself the object of their ridicule and devaluative attitudes, to the detriment of his emotional well-being. Teachers, lacking training in special education in general and deafness in particular, are either unaware of the deaf pupil's problems or unable to cope with them. Accustomed to the comfort and successes within the protective setting of the school for deaf children, the child is now experiencing an unremitting series of setbacks and failures in the area of social as well as academic performance. "Graduation" from the high school may not at all be a true index of his academic record. (Many deaf students are awarded a certificate instead of an academic diploma.) A tendency among proponents of this kind of educational integration is to exaggerate successes and to gloss over failures gives a distorted picture to other professionals and to the parents of deaf children. Some deaf youngsters have the basic innate psychological equipment to make the necessary adjustments. Others do not; they grope instead of cope.

Sussman (1970) reports that deaf students referred to him from these integrated educational systems for psychological assistance at a community mental health center, in general have been initially diagnosed as "situationally maladjusted," "adjustment reaction of adolescence," or "behavior disorder." However, after closer scrutiny, it is found that their symptoms indicate more serious emotional disturbances. Their emotional problems represent an acute reaction to overwhelming environmental stress. For some students, who have been in these regular schools over a longer period, what may have initially been transient disturbances have developed into conditions that are more resistant to treatment. In some cases there is enough pathology to warrant psychiatric attention and intensive therapy. While they are regarded as educationally integrated deaf students, we may be witnessing their psychological disintegration.

Sussman (1970, p. 22), however, cautions us that his experiences with these deaf children should not be construed as a polemic against the integration of all deaf children in regular schools. Integration has its merits. Highly selected deaf children, those who are found by expert diagnosis in depth to be emotionally stable, highly motivated, adequate mentally, possessed of stamina, graced with family support in depth among other governing characteristics, can and do thrive in these relatively competitive integrated school situations if the necessary supporting staff exists in quantity and quality. This supporting staff is crucial. It must include trained experienced counselors for deaf people through whom the deaf students can learn to come to grips with problems he faces in an environment that is shaped for normally hearing people and expert tutors for developing and maintaining communication skills and competence in language and subject-matter areas. A conditioning factor for true effectiveness is the operational climate of the program. It must stem from a philosophy that relates completely to student needs, not to matters of economy, budget, dollars.

The Subculture of Deaf People

Within the macrocosm of our culture there exists a microcosm made up of deaf people, often referred to as the deaf subculture or the deaf community. The subculture of deaf persons has its roots in their urgent need to nullify the communication barrier. In the regular community associations of hearing people, many deaf persons function marginally, on the fringe at best. They have to create compensations. Thus, they are able to operate in the larger culture as necessary, but they always have their own resources for satisfying social experience (Furfey and Harte, 1968; Schein, 1968).

Although deaf persons' major thrust in the hearing world is in the economic area, where they hold jobs and interact with hearing employers and fellow workers, they also are able to take advantage of what society itself has to offer in way of cultural and recreational pursuits. Deaf persons are known to be avid sports fans, attending their community's professional and school sports events; they frequent museums, the movies, public parks and relish every moment of it as do their hearing counterparts. They love, work, and play in ways that do not appear dynamically different from the way hearing people do these things. Deaf persons can establish adequate socialization patterns in the hearing world. However, qualitative and quantitative differences between deaf and hearing people in the nature of their social and community integration exist.

Within the deaf community, there are numerous opportunities for self-fulfillment in the social area that otherwise cannot be provided by society. It is within the context of the deaf community where the interaction of one deaf person with another is the greatest. Deaf people hold numerous civic, social, and recreational events and have many clubs and organizations of varied interests. The several national and approximately 35 state organizations provide leadership, recreation, safeguard rights, and promote group welfare. They established, own, and manage their life insurance company. Several hundred local clubs give opportunities for socializing and group welfare activity. For example, in New York City the Union League of the Deaf, with approximately 700 members, rents a ball-room size space in a Manhattan hotel that costs $12,000 a year. It is not uncommon to find a few other clubs housed in a small building owned outright by its members. Organizations of varied interests and leanings publish their own magazines and other periodicals. They sponsor a periodic World Congress of the Deaf and a World Games of the Deaf in addition to regular nation-wide and regional conventions in the United States. Several religious denominations have extensive and effective missionary programs among deaf people. And it is pertinent to point out that some groups of deaf people have their own churches and temples. In addition, there is a fair sprinkling of clergymen who are themselves deaf.

Unlike some other disability groups deaf people have always taken care of their own social needs. It is not a grammatical error that leads them to call their organizations clubs *of* the deaf. It is their way of emphasizing that they are not the recipients of other people's charity, that the disability of deafness does not foster incompetence. They have organized and supported these clubs themselves, with relatively little help from hearing people. Although the common denominator of organizations of deaf persons

is deafness, more and more hearing persons who live and work with deaf persons are now sharing membership in these organizations.

Another important factor is that the dynamics of stratification that are so powerful in organizations of hearing people, scarcely exist in organizations of and for the deaf. Thus, the range in human potential among the members of an organization of the deaf very likely exceeds considerably this circumstance in organizations in the larger culture. Consequently, deaf individuals' satisfaction in participating may vary considerably. Nevertheless, these organizations are important social and emotional havens for the bulk of deaf people.

The main pillar of the deaf subculture is the intermarriage of deaf men and women, although marriage between a deaf and a hearing person does occur. The selection of a deaf mate by a deaf person is due to social contacts in school and later in the deaf community. The ease and satisfaction of communication and the sharing of mutual problems inherent in deafness encourage such unions. Moreover, deaf individuals tend to gravitate to geographical areas where there is a greater concentration of deaf persons and organizations of deaf people, which provides bases for social contact that leads to marriage.

Despite the greater satisfactions and gratifications the deaf person finds in the deaf community, the dangers of provincialism must not be overlooked. For many deaf individuals, the subculture increases his unawareness of the flow of events in the larger culture. Thus, his proneness to be uninformed of matters that are important to him is intensified. One of the manifestations is his unawareness of his community's service programs. As a taxpayer and citizen, he is entitled to their services but often may not know of them and, consequently, not apply.

Another important problem is the cost of supporting the subculture at attractive levels. The small number of deaf people in relation to the many organizations in their social structure means thin budgets for all. Consequently, very few of the organizations are appropriately staffed by paid workers. Much of the important work is voluntary. Quarters are apt to be shabby and located in rundown areas.

Employment

Perhaps deaf people project their best image in employment. Their normal strength, mobility, and intelligence supply the base for good production performance. The large percentage who have attended residential schools for the deaf, in which they have had four or more years of training in a variety of shops such as printing, woodworking, bookbinding, shoe

repairing, machining, and so on, have acquired important knowledges and skills that are quite salable on the employment market. Consequently, most deaf people have found employment readily (Williams and Vernon, (1970).

This glowing picture nonetheless has three serious flaws. The first is that employed deaf people are very often seriously *underemployed*. The deaf college graduate linotype operator or pressman is quite common, for example. Everywhere we find deaf men and women of normal or above abilities operating automatic machines, performing simple assembly line operations, or otherwise occupied in unchallenging routines. This stereotyping illustrates the inadvertent discriminatory attitudes toward deaf job applicants that are inevitable among slightly informed professionals when relating to this or another very small minority that has very complex characteristics.

We must not, however, blame solely the labor market for not according the deaf person the opportunity to work at his potential. It is believed that many instances of underemployment and job dissatisfaction could have been prevented by proper guidance counseling in the schools for the deaf and vocational counseling services for deaf adults. The manpower waste is incalculable with respect to both the national economy and the deaf person himself (Schein, 1968; Vernon, 1970b).

The second flaw is the instant, usually permanent job plateau achieved by the deaf employee. The ladder for advancement in responsibility and function is seldom available to him. The essence of this situation is discrimination. In most instances it is inadvertent, arising out of ignorance, uncertainty, and lack of precedence on the part of the employer, and out of unawareness, lack of confidence, and unaggressiveness on the part of the deaf employee.

Little information is available about discrimination against deaf employees that relates to their earnings and working conditions. It is probable that some unfairness does exist in less organized job situations. However, it is generally believed that deaf employees receive equal rewards for equal work aside from the aforementioned fact that deaf workers are not given equal consideration for advancement due to misconceptions about the limitations of deafness.

Unemployment and marginal employment are common among the more severely handicapped deaf persons—those who have additional disabilities and/or emotional or other handicapping conditions that have not been controlled or remedied. While deaf people may be disadvantaged in job interviews, those who are severely handicapped are extremely ineffective

in displaying their abilities. Moreover, when in employment, they may not be able to cope initially with interrelationships without having understanding and dynamic supervision. The many who have been placed in appropriate competitive jobs and guided to a state of satisfaction and performance that reflects their innate abilities are money-makers whom employers are glad to have. Others whose adjustment problems do not yield to available services may find job satisfaction and a measure of independence in sheltered employment.

The third flaw in this occupational picture concerns what some writers have termed the second industrial revolution. This revolution has resulted from the rapid technological advances, commonly referred to as automation, which have occurred during the past two decades and which will continue on an accelerated level. Although automation threatens everyone to some degree, it poses some very special problems for the handicapped person in the labor force. This is because handicapped workers, particularly deaf persons, tend to be more heavily concentrated in the occupations where automation is making its greatest inroads (Tully and Vernon, 1965).

As recently as 1959, a survey of over 10,000 deaf workers revealed that 75 percent of the men were engaged in skilled and semiskilled manual occupations. This percentage is almost twice as high as that for all workers. Furthermore, over half of all deaf workers interviewed were employed in manufacturing, in contrast to 25 percent of the total population (Lunde and Bigman, 1959). When one considers that the occupations in which deaf persons have been engaged are the very ones which are now being the most rapidly automated, the severity of the problem comes into focus.

At the present time, despite the initiation and implementation of a handful of regional post-secondary training centers, vocational training opportunities for deaf adolescents and adults are extremely limited. Vocational and technical schools for the hearing may refuse to accept deaf students because of their lack of communication. On-the-job training is too seldom satisfactory. Another serious ramification of the technological era is that many new jobs require excellent communication skills or a high level of formal education. In other words, recent changes in the world of work have resulted in a decrease in the types of jobs in which deaf people historically have been successful and an increase in occupations that emphasize communication skills and formal education where deafness is most handicapping.

Virtually all the industrial and occupational trends foreseeable for the immediate and far future underscore the need for increased training opportunities and guidance for all deaf persons. The sparsity of effective

rehabilitation and vocational counseling resources for deaf persons is a condition that must be rectified. An important ancillary service in the education of deaf youngsters is the school counseling program that would prepare them to enter the work force. As regards the deaf adult who is displaced or affected in any way by automation, the need is for intensive and extensive vocational counseling with vocational *readjustment* as the goal.

Public Service

Very few public services have staff who are able to communicate effectively with deaf applicants. *Underservice* is the inevitable consequence.

Much more often than not, the deaf applicant for employment, welfare, health, or other public services feels that he has received only superficial consideration when the interview has been a communication contest. The interviewer who does not use the sign language and who is reluctant to write or who writes illegibly or at too high a vocabulary level is discouraging. Information about such an event travels rapidly in the tightly knit deaf community with the result that many needy deaf persons may avoid exposure to a similar negative experience. Instead they may gravitate to the nearest school for the deaf or to another situation in which they feel secure because of the availability of expert manual communication. Unfortunately, neither the school nor the other resource is apt to have the capability to provide the needed service. They usually try to refer the deaf person to the appropriate public service if they know about it. As a result, it often leaves the deaf person running futilely from pillar to post seeking assistance, to his utter exasperation.

This widespread practice has led to recognition of the need for coordinating and referral centers for deaf people in metropolitan areas so that they can and will receive needed services. Such centers identify the needs, arrange appointments, and provide interpreting at the interview if the circumstances so indicate. Adjustment and counseling services are also a part of these centers. Fewer than a dozen such centers now exist. Many more are in planning stages.

A second aspect of underservice of deaf persons by public agencies is the lack of awareness among deaf people about public service to which they are entitled and which they need. A part of this relates to the lack of staff who can communicate with deaf persons. Manual communication skill inevitably involves identity with the deaf community in one way or another. Such a tie by a public-service worker generates knowledge and awareness of what his official role is and that he is a source of help if

needed. The lack of awareness is also a by-product of existing isolation of deaf persons from the mainstream of community activity.

The use of sign language interpreters in public-service situations is valuable and often indispensable. More and more qualified interpreters are becoming available through the Registry of Interpreters for the Deaf, which is elevating interpreting to professional standards and status. While the emergence of interpreters is a boon for many deaf persons, it is by no means a panacea for all of their communication difficulties. Problems relating to interpreters may arise when a deaf applicant is defensive or resistant. They may also surface when the interview situation is highly confidential. Some deaf persons may be very reluctant to discuss personal problems and needs in the presence of a third party, the interpreter, especially if the interpreter is a family member or close friend. Situations in which a deaf person seeks welfare assistance or psychiatric treatment require highly confidential handling.

Paternalism

Social handicaps stemming from negative and devaluative attitudes of society toward people with physical disabilities are amply covered by the literature. Needless to say, deaf persons are not spared from such attitudes. A certain syndrome in the attitudinal picture that has an especially wide social psychological implication for deaf people is paternalism.

This is the bête noire of all deaf people. It is widespread, persistent, and pernicious. It thrives on the limited abilities of deaf people in speech production, on their low-achievement levels in language, and on their naïvete and lack of sophistication in common interrelationships. It has its roots in the communication problem. These group inadequacies have been the base for general attitudes of doing things *for* rather than *with* deaf people; of proceeding with substantive plans on their behalf without involving them in the planning process; of low aspirations for them despite the brilliance of substantial numbers (Vernon and Makowsky, 1969).

The limited speech skill and other inadequacies assume overwhelming proportions in the minds and reactions of many people and surprisingly so among educators, families, and other associates of the deaf. They are beset with apologias. They have ceased to think positively, to recognize that the deaf person is far more normal than abnormal and that he has more assets than liabilities. Thus, deaf people have generally not had the opportunities for participation in levels of living appropriate to their native abilities. They have not been able to demonstrate their capacities. Paternal-

ism undermines and negates the courageous efforts of deaf people to improve their public image and consequently their employability.

Concluding Remarks

The deaf person is generally in need of many types of community and counseling services. Deaf people as an underserviced disability group are underscored throughout this chapter. The preventive and treatment procedures are less than adequate for many reasons, especially the persistent, serious shortages in qualified personnel in the helping professions and places for service.

True, there is nothing we can do at present about irrevocable hearing loss. But there is no reason why deaf people cannot be helped to live more effectively, thus enhancing their psychological and social integrity. There are three reasons for optimism. The first is that deaf people have demonstrated their receptiveness to counseling and their capacities to benefit from it. Second, within the counseling professions there is an increasing awareness of the counseling needs of deaf people. Finally, important progress is being made with respect to the recruitment and training of professional counselors to work with deaf people of all ages.

CHAPTER II

Current Status of Counseling with Deaf People

McCAY VERNON

Improved, yet primitive, best describes the current status of counseling in the field of deafness. Services have expanded over the last decade and new training programs have been developed (Jones, 1970; Sussman, 1970; Switzer and Williams, 1967). Yet, the overwhelming majority of deaf people still go through life totally unable to obtain any form of professional-level counseling. The situation is best understood if examined as it relates to specific realms and periods of the deaf person's life.

Counseling for Young Deaf Children's Parents

When a family first discovers it has a deaf child the reaction is generally traumatic. Grief, guilt, and overwhelming helplessness are normal responses. These feelings and the accompanying anxiety leave parents desperate for help and highly vulnerable to anyone who offers direction, regardless of how inappropriate it may be. Effective counseling at this crucial time would enable parents to work through their feelings and direct their efforts and anxieties toward constructive endeavors for the deaf child.

Unfortunately, instead of professional help toward these ends, parents are generally exposed to the well-intended but often misguided counsel of speech therapists, educators, physicians, and audiologists whose competence and training is often excellent in their respective fields but not in the field of counseling. As a consequence parental needs to deny their child's deafness are reinforced (Grinker, 1969; Mindel, 1968; Vernon, 1969a; Vernon and Mindel, 1971). Hearing aids and speech lessons are offered as the major solutions to the parents' problem in coping with deafness

when, in fact, these are ancillary to the important tasks of psychologically working through the mourning of the child's hearing loss and of establishing very early communication through the language of signs and fingerspelling used in conjunction with speech, amplification, lipreading, and writing (Mindel and Vernon, 1971).

It is the lack of appropriate parent counseling at this crucial time, when deafness in the child is first discovered, that lays the groundwork for much of the later family pathology and related difficulties faced by parents and their deaf child (Sussman, 1970). Deaf youth frequently grow up unable to exchange with their own parents and siblings basic information about religion, human interaction, sex, work, and family life simply because of the absence of effective early parent counseling and resulting poor communication. The frustration and tension that this deprivation of communication introduces accounts in part for the high divorce rate among parents of deaf children and for the frequent appalling lack of closeness between deaf youth and their parents and siblings. The frequent vocational and educational difficulties that follow in adulthood are often a direct outgrowth of these early difficulties that could have been avoided with proper parental counseling.

The total failure of colleges and universities to prepare professionals for this counseling responsibility, in the face of the desperate need parents have, has obviously resulted in a counseling vacuum. It is currently being filled by almost anyone in the speech and hearing clinic, school, or doctor's office upon whom the task falls by default. The deplorable results alluded to above, but beyond the scope of this chapter to fully explain, are the usual consequences.

If the major psychological, educational, and vocational problems of deafness are to be met at the preventive, not the rehabilitative level, professional parent counseling is absolutely essential. At present it does not exist and there are no planned programs to prepare such counselors. The only training available is semiprofessional at best. It generally consists of indoctrinating teachers, speech therapists, audiologists, etc., to convince parents to use and support an "oral only" treatment of deafness which, though well intended, includes so much frustration and failure that it is in actuality often anti-therapeutic.

Counseling in Elementary and Secondary Schools

Public day schools and classes, with few exceptions, offer deaf youth nothing that could even euphemistically be termed professional counseling. Persons with the title counselor may do some class scheduling with deaf

students and talk with parents if discipline problems arise. However, almost none of these people are specifically prepared to understand the implications of profound hearing loss. Most cannot communicate in sign language, a prerequisite to counseling most deaf youth. In addition, they usually have only one or a few deaf students as part of a huge general case load.

The situation is sufficiently deplorable. Not only does the deaf youth have no one to come to with problems, but he cannot even obtain basic information about the programs available to him for postsecondary academic and vocational/technical education. The college, junior college, trade school, and evaluation and work orientation facilities created specifically for deaf youth are widely under-utilized, while hundreds of youth in need of them are unaware of their existence. The primary reason is the absence of even rudimentary counseling geared to young deaf people.

Obviously, if the deaf youth in day schools and classes and regular public schools cannot even get basic information about services available to him because of a lack of informed counselors who can communicate with him, he has no hope of receiving counseling regarding personal problems, career planning, etc. (Sussman, 1970).

In contrast to the day school situation, many residential schools have a psychologist and/or psychometrist, a social worker, or a counselor. However, the primary duties of these staff members usually involve diagnostics, intake, or administration, not actual personal or group counseling. Residence hall staff generally lack any professional preparation in counseling. Some of them have sensitivity to young people's needs and can function in a highly therapeutic manner. Unfortunately, such sensitive persons are in the minority. In many schools, residence hall counselors are unable or forbidden to use sign language, which precludes adequate counseling even if the staff were competent to provide it.

Residential school faculties are usually aware of most of the postsecondary opportunities available to deaf school leavers and inform the students and families about them. However, some schools advocating only oral education, especially the private ones, may often not tell the graduate or his family about specialized programs for deaf persons because of the school's desire to have the student matriculate in a facility with hearing students.

From the above, it is clear that there is a need for qualified counselors in the elementary and secondary schools of the nation, which now have some 40,000 deaf children. Whether or not administrators are willing to establish counseling positions and employ such people is another matter.

Certain progressive residential schools already have, and a trend toward enlightenment along this line seems a reasonable expectation.

Counseling in Postsecondary Programs

Some years ago, in the way of a major research and demonstration project, Gallaudet College established a counseling center which, plagued by many problems and possibly naïvete about deafness, was subsequently abandoned. Major reasons for the failure were that psychologists employed did not communicate adequately with deaf students; some did not master the sign language or consider it essential in counseling work with deaf students; and there seemed to be some confusion over whether the role of the center was counseling or tutorial. Recently, counseling services have been reinitiated at Gallaudet. The National Technical Institute for the Deaf has developed personal, academic, and vocational counseling services for its deaf students.

In the four-year program for deaf students at San Fernando Valley State College, and in most of the junior college programs, there is emphasis on counseling but the unavailability of professionally qualified counselors makes the goal difficult to achieve. These facilities, nonetheless, do recognize the need and do make strong efforts to provide counseling.

Special facilities such as the Hot Springs Rehabilitation Center for severely disabled persons and workshops and evaluation centers for deaf clients are also cognizant of the need for counseling. They too face the problem of finding qualified people.

Counseling in Integrated Educational Facilities

The deaf person who goes to a regular college, high school, or vocational training facility for the hearing is likely to receive no counseling at all. Ironically, he is the individual in the most stressful environment. Unless there is some centralization of deaf persons in a relatively few institutions, and unless the caliber of counseling available from the Division of Vocational Rehabilitation improves, it is obviously not feasible to provide them specialized counseling.

Counseling in Vocational Rehabilitation

Most deaf persons, by virtue of their handicap, are eligible for state rehabilitation services that include counseling. For many years the persons dispensing these services had no training as counselors and little, if any, experience with deafness. Hence, it was primarily bright deaf clients who

knew what they wanted and who knew their rights who got financial support for training. Others frequently were given job placement in laundries, assembly lines, or similar menial tasks unless they had learned a trade in a residential school. In these cases a few were given assistance in placement (Lunde and Bigman, 1959).

Today the educational level and professional competence of counselors are rising. Table 1 shows that of the 132 who were devoting at least one-fourth of their time to deaf clients some 35 percent held graduate degrees and 85 percent had at least a bachelor's degree. Approximately 13 percent held graduate degrees in rehabilitation counseling (Tully, 1970).

TABLE 1

Highest Degree Held by Vocational Rehabilitation Counselors Working at Least 25 percent of Their Time with Deaf Clients

Degree	N	%
Ed.D., Ph.D.	0	0.00
Ed.S.	1	0.76
M.A., M.S.	46	34.96
B.A., B.S.	67	50.92
A.A.	2	1.52
Other	11	8.36
None	5	3.80
No Response	0	0.00
Total	132	100.32

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These figures represent tremendous improvements over the past and a significant dividend from the graduate counseling programs sponsored by the Rehabilitation Services Administration. While they give encouragement for the future they must be evaluated against a background of some hard facts.

First, the majority of deaf clients are not seen by these 132 counselors who serve primarily in urban areas or in specialized facilities. Most deaf people who get any service at all are seen by general counselors who are unlikely to have any knowledge or experiences with deafness. Obviously they do not know manual communication, which is a basic prerequisite to counseling a deaf client. For that matter only one-third of the 132 counselors (18 percent of whom are themselves deaf or hard of hearing) specializing in deaf clients are good in manual communication (Table 2).

TABLE 2

Manual Communication Skills of Vocational Rehabilitation Counselors Working with Deaf Clients

Skill	Good		Fair		Poor		None		Total	
	N	%	N	%	N	%	N	%	N	%
Expressive ...	60	45.60	60	45.60	10	7.60	2	1.52	132	100.32
Perceptive ...	37	28.12	62	47.12	31	23.56	2	1.52	132	100.32
Overall	45	34.20	70	53.20	15	11.40	2	1.52	132	100.32

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Secondly, the responsibilities of counselors are so structured that only about one-fourth of their time is spent in counseling, the balance being devoted to clerical, public relations, and other functions (Table 3).

TABLE 3

Present and Desired Functions, by Percent of Time Spent, of Vocational Rehabilitation Counselors Working with Deaf Clients

Function	New		Should		Sig. of Diff. of Percents at .05 Level
	N	%	N	%	
Clerical work	124	11.03	119	4.76	1.805
Counseling and Guidance.....	124	26.77	119	34.14	—1.249
Overall planning of work	124	6.69	119	7.41	—0.219
Professional growth	124	5.53	119	7.82	—0.716
Public relations and program promotion	124	6.02	119	8.34	—0.701
Recording	124	11.17	119	7.11	1.096
Reporting	124	5.44	119	3.90	0.568
Resource development	124	7.59	119	6.27	0.405
Travel	124	7.66	119	6.54	0.340
Placement	124	10.29	119	12.07	—0.440
Other	124	2.19	119	1.66	0.300
Total		100.38		100.02	

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Thirdly, deaf people, especially the 60 percent who are educationally at a fifth-grade level or below, are notoriously hesitant to seek the help they need if they face the massive red tape and the interaction with people who cannot sign that is inevitable in present Division of Vocational Rehabilitation offices. Of course, it is this poorly educated segment of the deaf

population that needs services the most. The end result is a gross discrepancy between the need for rehabilitation counseling and the demand for it.

In sum, the overall picture of counseling in the Division of Vocational Rehabilitation is that primitive rudimentary service is available to some degree for almost any deaf person seeking it. True rehabilitation counseling is rare and case finding almost nonexistent (Stewart, 1971).

Counseling for the Emotionally Disturbed and the Mentally Ill

Nowhere is the glaring lack of counseling more apparent than in the treatment of deaf persons who suffer from emotional or mental disorders. Only one or two states have identified and serve deaf patients with qualified diagnosticians and therapists. A few other states have initiated such programs, but lack professional staff familiar with deafness and deaf people. The Langley Porter Neuropsychiatric Center in San Francisco has an excellent pilot program primarily for deaf children and their families, and provides parental counseling, psychotherapy, and other outgoing mental health services. At the federal level, Saint Elizabeths Hospital has an outstanding unit for deaf patients, which is the direct result of some 12 years of intense commitment to deafness. Although the Saint Elizabeths Hospital program provides training opportunities, it finds recruitment of qualified mental health personnel a most arduous task. An embryonic counseling and mental health service for deaf persons and their families is in operation within the Maimonides Hospital Community Mental Health Center, in Brooklyn, N.Y. This community mental health program, with an accent on prevention, is limited to serving deaf persons residing within the Borough of Brooklyn. Notwithstanding, its two part-time psychotherapists find it increasingly difficult to handle a burgeoning patient load.

The pioneering work of the New York State Psychiatric Institute, Michael Reese Hospital of Chicago, Langley Porter, Saint Elizabeths, and Maimonides has provided a workable model for mental health services to out-patient and hospitalized deaf persons. All that remains is implementation on a national scale. Unfortunately, with few exceptions inertia or apathy rather than action has been the rule in this kind of program development in most areas of the country.

In most states the deaf mentally ill languish in custodial isolation, unidentified and untreated. Their incarceration, which is what such hospitalization actually is, is often antitherapeutic and more of a convenience to society than an effort in treatment and rehabilitation.

General rehabilitation counselors are becoming increasingly involved in state hospital programs. Except for some isolated surveys of deaf patients in state hospitals this involvement has not yet reached the point where it is resulting in significant services to deaf people.

Pastoral Counseling

Historically, ministers, rabbis, and priests have probably provided as much counseling to deaf persons as any other professional group. Often unheralded, many of these religious workers have served as interpreters in rehabilitation settings, done job placement and marriage counseling, and in general been people to whom a deaf individual could turn for help. It is religious workers who have often identified and facilitated the rehabilitation of deaf patients in hospitals for the mentally ill and mentally retarded who were misdiagnosed and should not have been there.

The quality of pastoral counseling varies greatly. On the one hand there is the minister with the warmth and background needed to provide professional counseling. On the other is the "hell, fire, and brimstone" moralizer who tends to compound rather than solve deaf persons' problems. With the increasing emphasis being placed on pastoral counseling in seminaries and with continued interest by ministers, rabbis, and priests in deaf worshippers, there is basis for hope that pastoral counseling will increase in quality and quantity.

Marriage and Family Counseling

Aside from one abortive effort in this direction in a large West Coast city, the only service offered in marriage and family counseling has traditionally been by clergymen, some of whom lack training in marital and family relations, let alone a working knowledge pertaining to the psychodynamics of deafness. Needs in this area are great, as demonstrated by the New York and Chicago studies (Grinker, 1969; Rainer and Altshuler, 1963). Sussman (1970) includes such activities as the imparting of genetic information in premarital counseling and specific guidance for deaf parents with hearing children.

Other Types of Counseling

Counseling is a broad term, sometimes subsuming financial advice, legal assistance, job placement, tax guidance, etc. As a group, deaf people are much more in need of these and other kinds of social services and much less able to obtain them from existing agencies than is the general popula-

tion. Adult education and state associations of the deaf are meeting some of the needs in these areas. Recently community service centers have been established in Pittsburgh, Kansas City, Dallas, Seattle, St. Louis, and Chicago. These programs vary widely in quality and service offered but in all some form of counseling is available.

CURRENT ISSUES

Deaf Counselors

The concept of minority or disability groups being directly involved in their own rehabilitation at professional and decision-making levels is a valid one. Alcoholics Anonymous, Synanon, the Urban League, and countless other successful programs have shown that minority group members usually have better insights, more commitment, and greater rapport with their own than does the general population. Organizations such as the Bureau of Indian Affairs, black ghetto schools staffed by middle class white suburbanites, the Alexander Graham Bell Association for the Deaf, and educational programs for deaf children that exclude deaf teachers and administrators show that paternalistic or proselytizing approaches that exclude minority group members from key roles in their own rehabilitation are doomed to failure.

Due to federal policies, Rehabilitation Services Administration opportunities have been available to deaf students for professional preparation in graduate rehabilitation counseling programs. Counseling and administrative positions have been opened up for them following graduate study. The end result has been that in rehabilitation counseling, deaf professionals are involved at all levels, including policy-making. The increasing success of rehabilitation programs in deafness reflects this involvement.

Specialization in Deafness

Currently the counselor who specialized in the rehabilitation of deaf persons is entwined in a serious dilemma. In a state rehabilitation agency he faces, in deaf clients, a more difficult counseling task and the probability of fewer closures. As closures are a primary criterion of success, his record is unlikely to put him in a strong competitive position for advancement. Many of the most competent professionals are driven from the area of deafness for this reason. Adjustments in the "closure" system must be made in order to positively reinforce, not punish, the counselor who develops the additional skills required to be a specialist in deafness. As a corollary to this, the key positions in any state rehabilitation agency tend to go to the

generalist. Thus, specialization dead-ends the counselor for advancement into higher administration. Once again we have a situation wherein the more a person devotes to learning about and serving deaf clients, the less opportunity he has for promotion.

Florida has coped with this problem by giving large numbers of general counselors orientation programs to deafness and training in manual communication, and rotating them through service experiences with deaf clients. They develop some rudimentary counseling skills and an understanding of deafness, which over the years has pervaded the entire program in the state at all levels—a most positive circumstance. Yet, few if any persons getting brief orientation to deafness will obtain the highly developed skills deaf people need in a counselor.

The entire issue of specialization in deafness, and its consequences for the counselor, must be very thoroughly examined as part of any solid comprehensive planning. This examination has yet to be made, nor are there, at present, adequate plans to cope with the dilemmas created.

Decentralization

Currently, the Federal Government is advocating a decentralization of services, i.e., a returning of responsibility and control from federal to regional areas. As a general policy this approach has merit. However, for small groups such as deaf people, it is impossible at state and regional levels to even begin to provide basic programs of services and professional training. Eminently successful facilities such as Gallaudet College, the National Technical Institute for the Deaf, the Hot Springs Program for Severely Disabled Deaf Adults, the University of Arizona's Rehabilitation Counseling graduate program, and New York University's Deafness Research and Training Center would never have come about under such a decentralized administration. Their future and the entire future of counseling services in the area of deafness are jeopardized by decentralization. The recent gains in these areas will be lost and a return to previous dismally low levels of service will be inevitable if the Federal Government does not maintain and develop services on a national level.

Need and Demand for Case Finding

A major outgrowth of the three years of research on Chicago's deaf population was the discovery of a shocking gap between the need of deaf people for services and their demand for them (Grinker, 1969). This is a many faceted problem deserving immediate attention. For example, in

Chicago alone there were many times the number of multiply handicapped deaf persons than could be served in the Hot Springs Rehabilitation Center. Yet, these young adults did not know of the Center's services nor did their families, their teachers, their ministers, or even their D.V.R. counselors. This Center, ostensibly serving the entire nation, could be filled by referrals from one city. At the other end of the continuum were many bright deaf youths capable of college, junior college, or technical education who were oblivious to many outstanding programs of the permanent facilities like Gallaudet College and the National Technical Institute for the Deaf.

The problem is one of communication. The establishment of a good program is but the first step in the delivery of services (Hurwitz, 1970). Over the last ten years giant strides have been made in this initial step of starting facilities. The task of informing and counseling those needing the services has only begun. The eventual solution to this problem is a national, continually up-dated registry of deaf persons. Since at this time such a registry is not within the foreseeable future, other steps must be taken.

First, an annual listing of all postsecondary programs serving deaf clients should be sent to every counselor working with deaf clients, many general counselors, speech and hearing centers, and selected schools. This should list what kind of training is offered and procedures for enrollment. *Hearing and Speech News* published an initial effort in this direction, which, unfortunately, is only a token of what is needed and is not planned as an annual feature (Vernon, 1970a).

The gap between need of and demand for rehabilitation is an important reason for the low achievement of the deaf population and the increasing presence of deaf persons unnecessarily forced to accept welfare for lack of any known alternative. While its remediation may lack the drama and appeal of other steps, the communication gap is a correctable counseling problem and should be dealt with immediately.

Social Change and Counseling

Currently, we see increasing unemployment among deaf youth and predictions of an even worse problem in years to come (Sessions, 1966; Vernon, 1970b). With automation eliminating the jobs in which deaf people have historically been employed, and with present low educational levels precluding many available types of employment, there is tremendous need for increased counseling services of the highest caliber. If 70 percent of deaf people are to avoid the unemployment that John Sessions, AFL-CIO labor authority, predicts (1966), and if the remaining 30 percent are not to wind up in the dead-end jobs he forecasts for them, then current and

future needs must be met with immediate in-depth, long-term programs and planning. The complexity and rapid change of contemporary society requires that the deaf person be provided more than anachronistic, ineffective education followed by improving yet inadequate rehabilitation and counseling.

Black Deaf People

Currently, the black deaf population remains an essentially unidentified, unserved group (Schein, 1968). The problems of blackness and deafness in combination are not additive, but multiplicative. Case findings with these persons is essential. For example, the Chicago Mental Health Project was located in the heart of Chicago's huge South Side black ghetto, where needs for mental health services were overwhelming. Yet, the lack of black professional staff, the lack of organization of the black deaf community, and poor case finding resulted in very little demand for service. The problem is national and current efforts at its remediation minimal.

Psychodiagnostics

Counseling is often facilitated by psychodiagnostic data. Currently, there are no adequate interest tests, in-depth personality measures, or psychometric instruments that are usable with most deaf clients. The verbal content of the tests coupled with the verbal limitations of many deaf persons make the results of such measures invalid.

Current Status of Training

The number of professionally prepared counselors qualified to serve deaf clients of all ages is grossly short of both the need and the demand. Staffing the graduate programs required to fill this gap is difficult with present manpower resources. Currently, only New York University and the University of Arizona are producing significant numbers of fully trained professional counselors. The Universities of Pittsburgh and Illinois offered programs, but they lacked specialists in deafness and operate marginally. Until such specialists and specialized courses are provided, student interest in the field of counseling with the deaf is minimal. The orientation program at the University of Tennessee has contributed greatly, but it is of only three months duration, precluding in-depth preparation. It serves to familiarize people with deafness, but many of its students lack basic counseling training. Oregon has an orientation program similar to Tennessee's, but shorter.

Obviously, graduate preparation in counseling with deaf persons is primarily a void. Demands for such programs and for their graduates is both determined by and determines the services available to deaf people. Personal counseling, school counseling, parent counseling, and college counseling are fields of almost total undersupply, yet in these areas there are absolutely no adequate graduate-level programs preparing people in deafness or orienting existing professionals. This unmet need is crucial.

A similar vacuum exists in the supply of professionals to serve the emotionally disturbed and the mentally ill, the pastoral counseling field, and marriage and family counseling areas. In some of these disciplines there are scattered qualified professionals available, but no solid training program to meet needs.

Training grants and fellowship programs similar to those provided by Public Law 565 are now needed to meet the vast needs in counseling with deaf persons. The model provided by P.L. 565 would require little or no change to be broadened to underwrite counseling training. Similar programs have almost overcome what had seemed like an insurmountable under supply of teachers of deaf children. Such laws can perform the same service to the field of counseling if passed by Congress.

CHAPTER III

Principles of Counseling with Deaf People

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This chapter will do two things: first, it will present the nature and essential principles of counseling, and, second, it will consider the implementation of these principles in counseling persons who are deaf. The nature and principles of counseling with deaf people are no different than those which characterize counseling with other people. It is the application or implementation of these principles that will differ in some respects with deaf clients.

THE NATURE OF COUNSELING

It is difficult if not impossible to define counseling adequately in a brief statement. There are almost as many definitions as there are authors of texts in counseling. While there are similarities and overlappings in definitions, some include aspects that others omit. Rather than attempting at this point to give a simple, brief definition, or to summarize or combine definitions found in the literature, we shall describe the nature of counseling and the necessary conditions or essential principles of counseling.

What Counseling Is Not

It is sometimes useful to approach a definition by exclusion, designating what a thing or concept is not. This approach is particularly appropriate in the case of counseling, in view of the many misconceptions of what counseling is. Let us consider some things that are often considered to be counseling, but that are not counseling as a professional activity.

First of all, counseling is not the giving of information, though information may sometimes be given in counseling. Nor is the giving of advice, suggestions, and recommendations counseling. This is perhaps the lay concept of counseling and is the activity of people in the professions of law, medicine, and engineering that is often labeled counseling. But professional advice is not counseling, nor is a professional consultation a counseling relationship. The giving of advice should be labeled and recognized as such and not camouflaged as counseling.

Counseling is not influencing attitudes, beliefs, or behavoir by means of persuading, leading, or convincing, no matter how indirectly, subtly, or painlessly. It is not the process of getting someone to think or behave in ways that we want him to think or behave, or in ways we think best for him. Let us recognize the process of persuasion for what it is and not mistake it for counseling. Counseling is not brainwashing.

Nor is counseling the influencing of behavior by admonishing, warning, threatening, or coercing without the use of physical force. Discipline is not counseling.

Counseling is not the selection and assignment of individuals for various jobs or activities. Personnel work is not counseling, even though the same tests may be used in both.

Finally, interviewing is not synonymous with counseling. Interviewing is involved in the kinds of relationships listed above, as well as in other noncounseling situations. The intake interview to gather information about an applicant or client, or to orient him may be a prelude to counseling but it is not counseling.

It may seem to be very elementary to point out these things, but all of these are being done under the name of counseling. Counseling, in many if not most agencies concerned with rehabilitation, is seen as a way of doing something to a client, to get him to do what he should do, or what we think he should do, or what we think is good for him. Counseling is seen as a group of techniques utilized as devices to manipulate or influence the client toward the acceptance of the counselor's goals or objectives. Thus we hear such phrases as counseling the client into, or out of, a vocational field or objective, or counseling a client to accept this or that goal or objective, or toward this or that choice or decision. This kind of activity is not counseling, and it is a misuse of the term to call it such. Counseling is not something you do to, or practice upon, a client.

General Characteristics of Counseling

What then is counseling? Isn't it concerned with influencing and changing behavior? Certainly it is. If this were not the case there would be little point to counseling. Counselors are interested in changing the client's behavior. But counseling is a particular kind of influencing, with particular methods and goals. First of all, counseling is concerned with voluntary behavior change. That is, the client wants to change and seeks the help of the counselor in changing.

Second, the purpose of counseling is to provide the conditions that facilitate such voluntary change. These conditions respect the right of the individual to make his own choices. He is treated as an independent, responsible individual capable of making his own choices under appropriate conditions.

Third, as in any sphere of life, there are limits that are imposed on the individual. These limits are determined by the goals of counseling accepted by the counselor.

All counselors have goals that are determined by their values or philosophy and that influence techniques and methods of counseling. Goals apparently vary among counselors, and, although some counselors claim that their goal is only to help the client achieve his goals, they still do not accept all the goals of all their clients. Moreover, such a goal is sometimes a very narrow one and one that is still determined by the counselor and imposed on the client. A goal of counseling accepted by many counselors, and one that appears to be consistent with the goals of our society and with a democratic philosophy, is the development of responsible independence. This is a goal that, while determined by the counselor and imposed upon the client, maximizes the client's freedom in making specific choices. Thus, counseling is concerned with changing behavior by providing a situation in which the client who desires to change can become more responsible, more independent, more in control of himself and his behavior.

A common aspect of counseling is the interview. But, as we have seen, not all interviewing is counseling. There are those who feel we can do away with the interview. The application of conditioning in the changing of behavior is having a revival, and conditioning is being used in the interview to condition the verbal behavior of clients. This approach is called behavioral counseling, and it is suggested by some that the interview is not necessary for changing behavior by conditioning, so that counseling can be done without interviewing. But there seems to be a confusion here between behavior change and counseling or therapy. Not all behavior change is counseling, and while conditioning is a method of behavior change it is

not counseling. Thus, while not all interviewing is counseling, counseling always involves interviewing.

The same might also be said of another common aspect of counseling —listening. All counselors listen to their clients, at least some of the time. But not all listening is counseling. Many other people listen to others at times. To be sure, the counselor listens in a special kind of way, but so do some other people sometimes.

The counselor understands his client. But again, so do others understand people, although again the counselor usually understands better and in a different sort of way. But the difference is quantitative rather than qualitative, so that we cannot say that understanding alone differentiates counseling from other situations.

Counseling is conducted in privacy, and the discussion is confidential. But there are other private and confidential interviews, such as those between the doctor and lawyer and their clients, for example, and between the priest and parishioner in the confessional.

None of these characteristics, by themselves, constitutes counseling, or differentiates it from all other interviews or interpersonal relationships. Counseling involves an interview, in which the counselor listens and attempts to understand the client, or counselee, in privacy and with an understanding that what the client says will be held in confidence. It is expected that there will be a change in the client's behavior, in some way or ways that he himself chooses or decides, within limits. This seems like an acceptable definition of counseling. But is it adequate? Not if, as has been indicated, it does not distinguish counseling from other relationships. Even the presence of all these factors does not differentiate between counseling and some other kind of relationship that we would not consider counseling. What is there, then, about counseling that is different?

There are two other characteristics that are necessary for a counseling relationship. One is that one of the participants, the client, has a problem. Nor is this any kind of a problem, since the clients of lawyers, doctors, and engineers have problems. The client of the counselor is a person with a psychological problem. Second, and following from the first, the counselor is someone who is skilled in working with clients with psychological problems. This obviously requires some specialized training or preparation beyond that which the usual person has and different from that which other professional people have. This preparation and training is psychological in nature.

The unique aspect of counseling, then, is that it is a relationship between a client with a psychological problem and a counselor who is trained

to help clients with such problems. This relationship shares many of the characteristics of other relationships, including relationships between other professional persons and their clients. It also has the characteristics of all good human relationships. These include acceptance of and respect for others, understanding, mutual confidence and trust, genuineness, sincerity, openness, honesty, and integrity.

Specific Characteristics of Counseling

One may ask, however, if counseling is nothing more than the practicing of good human relationships, why it is so difficult to become a counselor—why shouldn't everyone be a counselor? To some extent, everyone who practices good human relationships is a counselor, at times, with some people. But there are certain characteristics of counseling that set it aside as a specific kind of relationship.

In the first place, the principles of good human relationships, though many of them are known, are not obvious, nor necessarily natural, nor easily practiced. If they were, we should be much more advanced as a society, much happier, with less mental disorder or disturbance than is the case at present. The understanding of the nature of good human relationships is something that must be learned.

Second, the practice of these principles requires training and experience. The ability to apply the principles is related to the psychological characteristics, or mental health, of the individual applying them. It is not a matter of information or knowledge; it is a matter of attitudes.

Third, the implementation of these principles in a counseling relationship differs somewhat from their practice in everyday relationships. This is because the counseling relationship is a special kind of relationship. It is a formal relationship between two persons who may, and perhaps preferably, have no other relationship. The counseling relationship is for the sole purpose of improving or restoring the mental health, adjustment, or functioning of one of the participants. The counselor consciously and purposefully practices or applies the principles of good human relations for the benefit of the counselee.

Fourth, the relationship is usually established between a trained individual and another individual who is in need of help or assistance by reason of being disturbed, unhappy, or in conflict because of an unresolved problem or another condition resulting in dissatisfaction with himself, or lack of self-respect or self-esteem. Whereas the application of the principles of good human relationships in general is for the purpose of maintaining good mental health among normal, or average, individuals, their applica-

tion in counseling is to restore or improve the mental health of disturbed persons.

Fifth, the relationship is established at the request or desire of the disturbed individual, is continued at his wish, and is characterized by certain conditions: privacy, confidentiality, set time limits, and regularity, on an appointment basis.

Sixth, the counseling relationship, even though it is a formal relationship and may be limited in terms of time relative to the life of the individual (seldom more than an hour a day, more often an hour a week), is a closer, more intense, and deeper relationship than any ordinary social relationship. This is due to its purpose and to the application of the principles of good human relations in their purest form, divested of the formalities of the usual social relationships.

The Conditions Offered by the Counselor

The counseling relationship is one in which an atmosphere is created in which the individual is able to take responsibility for himself, to begin developing, or restoring, the self-esteem that is necessary for his functioning as a healthy, responsible, independent human being, able to make adequate decisions and resolve problems.

This therapeutic atmosphere is created when the counselor offers or provides certain conditions to the client. These conditions are more dependent on the attitudes and feelings of the counselor than upon any techniques which he uses. They are expressions of the basic philosophy of the counselor toward other people. There are three basic beliefs, assumptions, or attitudes:

1. Each individual is a person of worth in himself.
2. Each individual is capable of assuming responsibility for himself, and can, and will under appropriate conditions, become a responsible, independent, self-actualizing person.
3. Each individual has the right to self-direction, to make his own decisions, to choose or select his own methods or means of achieving self-actualization.

There are at least three essential conditions that are necessary if an atmosphere is to be created in which the individual can take responsibility for himself and his development into a self-actualizing person:

The first is a deep respect for the client, an acceptance of him as a person or worth, as he is, without judgment or condemnation, criticism, ridicule, or depreciation. It is a respect that includes a warmth and liking for the client as a person with all his faults, deficiencies, or undesirable or

unacceptable behavior. It is a deep interest and concern for the client and his development.

A second major characteristic of the atmosphere or conditions for client progress is understanding on the part of the counselor and the communication of this understanding to the client. It is important to recognize just what is meant by understanding. The kind of understanding that appears to be most effective in counseling is not knowledge of or about the client. It does not consist of the results of a battery of tests, nor of the data in the client's record, nor of extensive case studies, no matter how voluminous or complete. The understanding that appears to be most effective is an empathic understanding. It is understanding that has no trace of evaluation or judging, nor categorizing or labeling in terms of some problem areas or complex, presumed etiological, or causal conditions. An empathic understanding is a "feeling with" another, the entering into his frame of reference—the internal rather than the external frame of reference—so that one sees the world and the other person, insofar as possible, through the eyes of the other. The counselor places himself, or attemps to place himself, in the client's place. He realizes that in order really to understand another's feelings, attitudes, and behavior, he must see things as the other sees them. For one does not behave in response to the world as it exists—or is assumed to exist—in "reality," but in response to the world as one perceives it.

The third major condition of a good counseling relationship is genuineness. The counselor must be real, honest, freely and deeply himself. He is not playing a role—there is no such thing as a counselor role, which a counselor assumes when he enters the counseling office or when the client enters his office. He has no facade that he places between himself and the client. In addition, there is no conflict between what he thinks and feels and what he says. This does not mean that the counselor must blurt out all his negative feelings or hostility, since this would be unlikely to be helpful to the client, but that he does not present a false friendship or liking.

A central element of the counseling relationship characterized by these conditions is the absence of threat. Although it may appear to be a negative way of looking at counseling and mental health, the concept of threat appears to be extremely important. Threat to the self and the self-concept seems to be the cause for personality disturbances or poor mental health. The basic need of the person is the preservation and enhancement of the self; all other needs or drives are subsumed under this. Frustration of or threat to the satisfaction of this basic need results in a lowered evaluation of the self; a loss of self-esteem is the core of personality disturbance.

The influence of threat upon behavior has been demonstrated in many areas. Perception is narrowed, so that the individual literally does not see many aspects of the situation. Under threat the individual may withdraw, even to the point of freezing under extreme threat, being literally paralyzed with fear. On the other hand, under less extreme threat, the individual may become defensive or aggressive. It may be that what has often been considered instinctive or natural aggressiveness is always a reaction to a threat, a reaction that is universal because threat, in some form or other, is universal. That is, while threat, or frustration, may lead to other reactions besides aggressiveness, aggressiveness is always a result of threat or frustration. Another method of defense against threat that may occur in addition to not recognizing or seeing it is self-deception which serves as a method of avoiding loss of self-esteem, or of restoring it.

In everyday life we are aware of the results of pressure or threat. The individual is unable to perform effectively or efficiently. He is unable to learn easily; he persists in ineffective attempts at problem-solving rather than in fruitful exploration. We know that we create resistance when we attempt to change people by pressure or threat, from the child who becomes more insistent on doing what he wants to do, to the girl who insists on marrying the clearly unsuitable boy to whom her parents object.

Changes in attitudes and behavior, self-actualization, the development of independence and responsibility—in short, mental health or adequate personality development—occur only under conditions of absence of serious threat to the self and the self-concept. Since the goal of counseling is the preservation, or restoration, of good mental health or of self-esteem and the fostering of self-actualization, then it follows that the counseling situation must be characterized by an absence of threat. Respect for the client, interest in and acceptance of him as a person, absence of evaluative attitudes, and understanding him by seeing his point of view—all contribute to an atmosphere devoid of threat.

Implementing the Conditions

Our emphasis has been upon the attitudes of the counselor as forming an atmosphere in which the client can achieve a feeling of security and self-esteem. But what does the counselor do; how does he act; what does he say? How does he express these attitudes; how does he understand the client and convey this understanding to him? While the attitudes of the counselor are of first importance, their implementation must also be considered. Their expression in a therapeutic manner is not usually natural or automatic. And while it is true that their expression must become natural,

so that the counselor may be himself, genuine and not playing a role, it is also true that he must be his counseling and therapeutic self, not his social or even teaching self.

The objectives of the counselor are to show his genuine interest in the client, to show that he accepts the client as someone worthy of respect and esteem, and to understand the client and communicate this understanding to him. How can the counselor do this, while at the same time allowing the client to be responsible for himself, for his behavior and decisions, including his communications to the counselor, from the beginning of the counseling process?

The methods or techniques by which this can be accomplished appear to be simple, and yet they are often difficult to practice. The first, and basic, activity of the counselor is listening. To listen is often a difficult thing for a counselor to learn. It is difficult to listen to another because one is thinking about what one wants to say. This kind of listening in order to have one's say in turn is not what is meant by listening in counseling. Listening is not, on the other hand, a passive thing, but an active following of what the client is saying or trying to say. It is listening without interference by one's own personal reactions or associations. The counselor's attention and interest are concentrated upon the client's communication. The listening is complete, in that the client is given freedom to express himself as he desires, to tell his story in his own way, without interruption, without questioning, without probing, without judgments. Remember that the counselor is not a Sergeant Friday trying to get "the facts," but is trying to see things as the client sees them. He is not concerned with obtaining an ordered, complete life history, to be recorded and filed away, but in helping the client express his attitudes, feelings, concerns, and perceptions of himself and the world.

Listening in this manner to what another has to say is a simple but basic manifestation of interest and respect; the client is worth listening to, and what he has to say is important. It is the first step in the client's taking responsibility for himself. The client who begins by asking the counselor what the latter wants to know, what the counselor wants him to talk about, or who suggests that the counselor ask him some questions, is expressing his dependency, his lack of responsibility and self-esteem. The counselor responds by pointing out that the client may decide what he wants to talk about, that the counselor is interested in whatever he has to say, and that the counseling time is his to use to discuss his concerns.

Listening of this kind is the basis for empathic understanding. It is the way by which the counselor is able to learn how the client sees things

and thus is able to perceive from the point of view of the client. Listening and understanding are the basis of, or perhaps constitute, empathy. Empathy is the ability to place oneself in the place of another, to take his role as it were, and to think and feel as he does.

While listening is perhaps the most important way of showing interest in and respect for the client, there are other ways of expressing interest and respect. Simple acceptance responses, such as "Yes," "I see," "Uh huh," or "Mm . . .Mmmm," are useful. These responses also may represent the second major class of techniques or responses used by the counselor. They indicate to the client that he is understood by the counselor. Simple acceptance responses, of which the above are illustrations, indicate that the counselor is following the client. The simple statement, "I understand," may be all that is necessary at times. To some extent simple restatement of the client's statements, usually called reflection of content, indicates to the client that the counselor understands.

But perhaps the most appropriate way of communicating understanding is by what is known as reflection and clarification of the client's feelings and attitudes. Reflection is the attempt to understand from the client's point of view and to communicate that understanding. The ability to reflect and clarify the feelings and attitudes of the client requires genuine understanding, based upon empathy. It requires skill in focusing upon attitudes and feelings expressed by the client, rather than attention to the content or the objective facts being expressed by the client. In counseling, the significant facts are the attitudes and feelings. This skill must be acquired through training and experience, including supervised practice in counseling.

It is important that the counselor not pretend that he understands when in fact he does not. If the counselor is not able to follow the client, which may happen when the client is confused himself, then he should say so. He may say, "I don't follow you," "I don't understand", or "I'm not sure I know what you're saying." Or if the counselor has some idea but is not sure of what the client is expressing, he may say, "Is this what you are saying . . .?" or "Let me see if I follow you. Are you saying . . .?" etc. It is not necessary, indeed it is impossible for the counselor to understand completely all that the client says or feels. He may misunderstand and show this in his reflections. But the client will correct him if a non-threatening atmosphere is maintained. As long as the client feels that the counselor is trying to understand him and shows some evidence of doing so, it appears that progress can occur.

The application of the simple methods described above, at least by a skilled and understanding counselor, appears to be effective in helping

clients. These seem to constitute the necessary and sufficient conditions for therapeutic personality change. It does not appear to be necessary for the counselor to question, probe, interpret, give advice, etc. Such techniques are inconsistent with the assumptions and goals of counseling. Interpretation, questioning, and probing may be threatening to the client. Support, persuasion, and advice may prevent the client from assuming responsibility for himself and for the solution of his problems.

It will be noted that no techniques for achieving rapport have been prescribed, because such techniques are neither necessary nor desirable. They are usually the result of insecurity on the part of the counselor rather than the need of the client. Counseling is not a social relationship, nor a social conversation, and should not be begun as such. If the client has come to the counselor voluntarily, he has not come to discuss the weather or the pending football or basketball game. And if he is referred and comes involuntarily, he knows he was not sent to discuss such topics. The counseling interview should be started simply and directly, recognizing what the client comes for. "What's on your mind?" "What would you like to talk about?" or "Where would you like to start?" are usually all that is necessary to begin the counseling session.

Rapport is not something to be achieved by artificial techniques or social devices. It is something that develops and exists where the counselor is genuinely interested in the client and his problems. The expression of the attitudes described above are sufficient for the establishment of rapport.

It must be emphasized again that counseling is not a matter of techniques, even the techniques suggested above. Counseling is a relationship in which the attitudes of the counselor are expressed. This expression must be genuine and spontaneous, not labored or self-conscious. It would perhaps be better if we abandoned the word technique, since it has connotations of being a deliberate, conscious, artful device for achieving a goal, even of manipulating a situation. The expression of the attitudes of the counselor in the counseling situation is not a matter of technique in this sense. It is a matter of making known to the client his respect, his interest, and his understanding in simple, genuine, spontaneous natural ways.

The Clients Activity

We have discussed the conditions of counseling that must be provided by the counselor and have indicated that these conditions, when presented and communicated to (or perceived by) the client, lead to such outcomes

in the client as appropriate (for him) decisions or choices, increased independence, responsibility, increased self-esteem, or more self-actualizing behavior. But what is the client's contribution to the process? What does he do in the counseling relationship?

These conditions, which minimize threat, permit the client to engage in the process of self-exploration. It becomes possible for the client to examine himself and his situation, and to see or recognize aspects of which he was unaware or not clearly aware.

Self-exploration is a complex process. It begins with self-disclosure. In the safety of the counseling relationship, where the client realizes he is not being judged or evaluated, he is able to disclose, or expose, his innermost and often most negative self, perhaps for the first time in any relationship. He is thus able to recognize and, if not accept, to include in his self-concept aspects that he has been unable to recognize. He thus develops a more complete or realistic picture of himself. With this disclosure of himself, he is then able to explore himself, in relation to others and to his situation. His thinking is more complete and more accurate, because it includes elements and aspects that were not present before. In addition to negative and undesirable aspects of himself, he comes to recognize positive and desirable aspects. As a result of his self-exploration, he develops more self-awareness. He becomes aware of his potentialities and possibilities, of the self that he could be.

To summarize thus far, then, we can say that counseling is a relationship. It is a relationship between a client who has a psychological problem, and a counselor who by preparation and experience is able to help the client resolve this problem. The problem here is not simply an immediate, temporary, specific problem, but may be a problem in the broad sense of what kind of life the client wants. Since counseling is a relationship, it is not a matter of techniques. Counseling is not so much what a counselor does as what he is, not what he can do for the client in terms of goods and services, but what he can give of himself. It is not restricted to tangible, concrete, limited outcomes, such as good vocational choices or other decisions with placement in employment, etc., but is concerned with whether the client has maintained or improved his self-esteem, his respect, his independence, his status as a human being—in short, whether he has become a more self-actualizing person. This is the goal of all counseling whether educational, vocational, rehabilitation, marital, or therapeutic. Such an outcome is not achieved by techniques or the giving of material things, but only as a result of a good human relationship.

THE NATURE OF COUNSELING WITH DEAF PEOPLE

Counseling with deaf people has received little attention in the literature on counseling. A recent review found that prior to 1970 there had been no research on the relationship, the process, or outcome of individual or group counseling with deaf clients (Stewart, 1970). While there have been brief discussions of problems in counseling with the deaf (Blish, 1955, 1964; Fusfeld, 1954; Goetzinger, 1967; Gough, 1945; McDonald, 1935; Mueller, 1962; Myklebust, Neyhus and Mulholland, 1962; Rudloff, 1965; Thompson, 1964; Vernon, 1967c), there have been few reports of how such counseling is implemented, and these were based primarily upon experience with hospitalized deaf patients (Rainer *et al.*, 1963; Grinker, 1969). Thus, counselors have had little guidance on how to implement general principles of counseling with their deaf clients.

Several writers have suggested that counseling with the deaf is a most difficult task because of the communication barrier. For example, Rainer and his associates at the New York State Psychiatric Institute (Rainer *et al.*, 1963; Rainer and Altshuler, 1966, 1967) maintain that psychoanalytic therapy is impossible because of the need of the deaf patient to face the therapist instead of lying on a couch. They also list limited social flexibility as well as low frustration tolerance and motivation as obstacles to therapy with the deaf patient.

It is here postulated that the nature and principles of counseling with deaf people are no different than those that characterize counseling with other people. Rather, it is their implementation that differs. This position is based upon a recent study and personal clinical experience with deaf clients. Stewart (1970), for example, found that the perceptions of the counseling relationship in group counseling with deaf clients were similar to the perceptions of hearing clients in individual counseling as reported by Rogers, Gendlin, Kiesler, and Truax (1967), Spotts (1962), and Barrett-Lennard (1962).

We shall now discuss general principles of counseling deaf clients, their characteristics, how these affect the counseling process, and how to cope with the problems involved. A final section will deal with special considerations such as information giving, confidentiality, the use of tests, and client expectations.

General Principles of Counseling and the Deaf Client

Obviously, effective communication between the counselor and the client is essential. This in turn is contingent upon the client's ability to

express himself in verbal or nonverbal ways, as well as upon the counselor's ability to communicate with the client and his willingness to enter into the client's own frame of reference. The two must have a more or less common language, and the counselor must have some knowledge of the factors that have gone into the client's development.

Second, the counselor must experience a warm, accepting, and nonjudgmental regard for the client. This ability is dependent not only upon his attitudes toward people in general but also on an understanding of the particular client as a person.

Third, the counselor must be genuine or congruent in his relationships with his client, and this is at least partly dependent upon acceptance of the client as he is. Lack of acceptance would mean that the counselor would have to either express this conditional acceptance or hold back his feelings and thus be incongruent.

Finally, the attitudes experienced by the counselor must be communicated in some way, or the client will fail to experience the conditions necessary for positive growth.

Significantly, the inability to communicate effectively with others is the deaf person's greatest difficulty and the most common obstacle between the counselor and the deaf client. Moreover, this barrier is far from being a simple one of the limited ability to exchange words. It is much more. Communication is made difficult by the underdeveloped language skills and vocabulary of most deaf people; by conceptual limitations and experiential deprivation; by the effects of having experienced life without the influence of sound; by the effects of impoverished interpersonal relationships stemming from communication deficits; and by the unique life circumstances of deaf people, which may be incomprehensible to the counselor who is unfamiliar with the impact of deafness on the individual's educational, personal, social, and vocational adjustment.

In order to experience the therapeutic conditions basic to successful counseling and to communicate these to the deaf client, the counselor must (1) understand certain facts about deaf people; (2) be aware of the special problems experienced by the deaf; (3) know the impact of these problems so that their impact on the counseling relationship may be minimized; (5) be able to communicate with deaf people in their language; and, (6) be aware of ways that deaf clients can be helped to better express themselves. The following discussion will deal with these issues separately.

Assumptions About Deaf Clients

There are several assumptions the counselor should make about deaf people and his work with them. These are related to the ways in which deaf people are, first of all, people, rather than the ways they are different from others.

First, there is a tendency for most people unfamiliar with the deaf to see them as totally different from others. This is an erroneous perception, for *in most respects* deaf people are more like those with hearing than they are like one another. We may speak of a "psychology of deafness" if we are referring to their special learning and adjustment needs, but if we are using the term to suggest that all deaf people learn according to unique processes, or have unique personalities, then its use is unjustified. We might as well have a psychology of the Negro, of the Jew, of the Catholic, of the northerner, of the southerner, and so on and on. Thus, we may state as one helpful assumption that *there is no unique psychology of deafness in the sense that deafness automatically and invariably results in a set of needs, learning patterns, and motives that differ markedly from those of the normally hearing.*

A corollary to the foregoing is that *deaf people have the same psychological needs as other people.* In no way does deafness alter the person's need for love, esteem, acceptance, productivity, and independence. Certain needs may be greater than others, but the magnitude and intensity of these needs are based upon the same factors operating on other people.

Second, *deaf people have within themselves the potential for resolving their difficulties and growing toward responsible independence.* This assumption is important in that the counselor may tend to underestimate the deaf client's potentials because of negative impressions created by the communication barrier.

Third, *the elements of privacy, confidentiality, set time limits, regularity, and the like are all integral aspects of the counseling interview with the deaf client.*

Characteristics of Deaf Clients

There are a number of characteristics of most deaf people that present unusual difficulties in the counseling process. The range of abilities and needs among deaf people is as great as, or greater than, among the hearing. Yet, within this range, deaf clients do tend to have more of the following characteristics.

Language Limitations. Most deaf people are seriously handicapped in

their knowledge and use of language, although many possess verbal or linguistic abilities that are superior to the majority of hearing people. Their handicap is manifested in poor reading ability, underdeveloped vocabulary, and language where syntax and meaning are either distorted or incomprehensible. Even in those cases where fairly good language is present, richness and depth of expression may be limited when communication is through the modalities of writing or speechreading since these are slow and laborious.

This creates two major problems. One, the counselor must be able to express himself in a manner understandable to the client. Two, he must be able to understand the client's poor syntax or words that do not adequately convey the nuances or depth of the client's feelings.

The ability to understand what a deaf client is trying to say is not easily acquired because the problem may be that of either emotional blocking, inadequate communication skills (speech, speechreading, writing, and even manual communication), simple refusal of the client to talk about himself, or any combination of these. Extensive experience is required before the counselor can hope to deal effectively with the language problems of a deaf client. In addition to learning how he can phrase his own remarks so that the client can understand them, he must learn how to understand the forms of expression used by many deaf people.

The excerpt below was taken from a counseling session involving a 19-year-old congenitally deaf youth with a long history of emotional disturbance and behavioral difficulties. The content illustrates (1) the irregular syntax previously mentioned; (2) the problem of omitted tense and verbs; (3) the low level of understanding on the part of the client; (4) the fact that the counselor, although having a good command of English, used a manner of expression comparable to the client's; and (5) the questioning approach taken by the counselor, which is often necessary in order to stimulate the client to elaborate. It is to be noted that both the counselor and the client used manual communication.

Client: Me worry, worry. Hurt body. Headache. Feel not good Don't know wrong . . . (pause)

Counselor: You worry much, that can make your body hurt. Next, your pain makes you worry more. It is same circle. Worry, pain, more worry, more pain. But you can't understand why you worry in first place, and your hurt body scares you.

Client: Yes! Yes! (with emphatic agreement). Maybe something bad wrong body (looks dejected).

Counselor: I think you feel bad . . . disappointed . . . and sad . . . because your body hurts you much and you not know what to do.

Client: (Nods head "Yes") . . . (Points to hip and signs "hurt," points to stomach and signs "hurt," signs "headache," then shrugs in a dejected manner) . . . (long pause)

Counselor: Tom, last week you told me you went to doctor for body examination (test). You told me he said nothing wrong. He said you nervous. You understand doctor?

Client: Yes, understand doctor said . . . (Makes face showing disgust) . . . doctor stupid . . . real hurt stomach, hip, headache . . . me nervous, yes, yes, but true hurt. Need hospital.

Counselor: I believe you. If you say you hurt, you hurt. I know the doctor believes you. He not think you lie. But maybe you not understand what doctor means. He means nothing bad wrong . . . He means he can't help you with medicine, operation, or other things. Doctor thinks you hurt because you worry . . . nervous . . . Doctor thinks if you stop worry, your body stop hurt . . . You think doctor right?

Client: Maybe (seems unsure) . . . how stop hurt?

Counselor: You, your doctor, and myself can work together and help your pain stop. You can help yourself most by thinking about what doctor said . . . follow what doctor said . . . and understand why you worry much. Can you tell me what doctor told you stop hurt?

Client: Give medicine (Shows counselor bottle of tranquilizers). Three times every day . . . morning, noon, night . . . (pause)

Counselor: You take medicine right time every day after finished doctor?

Client: Yes.

Counselor: Doctor told you take medicine. You take medicine right time every day. What else doctor tell you.

Client: Doctor said not worry . . . said come talk you . . .

It is important to point out that the deaf client's language should in no way be considered an indication of his level of intelligence. Rather, it is more a reflection of age at becoming deaf, type and degree of deafness, interaction with family members during childhood, and early education.

Conceptual Limitations. Individuals who have been deaf since birth or early childhood often have limited ability in dealing with concepts that have no immediate and specific referrents. This problem may result from language limitations, isolation, and lack of adequate stimulation during the

developmental years. The following, taken from an interview with a client (Jimmy) having limited language comprehension, is an example of the difficulty caused by inability to understand a concept mediated by language.

Counselor: What I hope to do is help you look at yourself and understand yourself as a person. Who is Jimmy? What is Jimmy like behind? I want to know more about Jimmy.

Client: Behind? (Looks around behind himself) Who behind? (Looks puzzled).

Counselor: I mean, who are you, really? Who is Jimmy?

Client: Me? Me Jimmy. (Nods head affirmatively). Name Jimmy.

Counselor: But I don't really know you, Jimmy. Maybe what you seem to be on the surface and what you are like inside are two different things. So, what is the real Jimmy like? Who is the boy behind Jimmy?

Client: Behind? (Looks around again, then back at the counselor, a puzzled frown on his face). Me Jimmy . . . I'm a boy.

Counselor: That's not what I mean. I want to know what you really think and what you really feel, who you are inside. I don't think I know what you think, what you feel. Can you tell me?

Client: (Obviously puzzled, frustrated, and a bit angry) Not understand! How feel? How think? About what?

The session continued in this manner, to the mutual frustration of both the client and the counselor, simply because the latter failed to grasp the fact that his client did not understand the figurative meaning of "behind." As in the first interview, the above client was of average or above intelligence but could read and comprehend language only at approximately the third-grade level.

A client's conceptual limitations may affect the counseling process in several ways. First, the client may present only a very gross picture of his problems or may fail to discuss his feelings since these are less clear and observable to him. He may mention specific things that bother him but may fail to recognize the affective nature of his difficulties. The counselor may have only a very brief sentence or two to aid him in understanding the client's thoughts and feelings at the moment. In turn he may ask a question or make a statement that has no immediate meaning to the client, and the communication gulf widens. As an illustration, the counselor may say to the client, "Tell me about how you are getting along with your boss." The client will most likely respond with a brief "Fine!" or "Lousy," and may not even understand at all unless sign language is used

in the expression of the initial question. A counselor statement such as "You really are angry (or hostile) toward yourself" may go entirely over the client's head. The client may pick up only the idea that the counselor thinks he is angry, but the idea of self-directed anger may be lost. Statements like "Mmmm . . . I see what you mean," "I can understand how you might feel that way," and "I guess you feel pretty bad about things now," may be equally ineffective and meaningless.

There is much the counselor can do and say with the low-verbal client, but these must be done in a vernacular the client can grasp. For example, the counselor might say, instead of the above, "Is your boss nice to you?" Or "Are you happy at work?" and "Tell me what you are doing at work." To express understanding, the counselor can nod his head and say "I understand"; and when expressing feeling, more nonverbal (bodily) cues should be used. The briefer and more specific the counselor's statements, the better will be client understanding. What happens is that the counselor cannot ask the open-end, unstructured questions he would like. Instead, he is forced into structuring questions as well as the client's reply.

In order to make the discussion thus far more meaningful, the following case history and a related counseling session are provided. No comments will be made concerning the counseling session, but the reader is urged to look for examples of the points already made.

Carol, a 20-year-old woman who was born deaf, was referred to a rehabilitation center program for the deaf because she could not keep a job. The referring counselor commented that "she was constantly agitated on her last job; every day she would become angry with her fellow workers and supervisor and make angry gestures at them. On several occasions she actually hit a co-worker, which finally led to her discharge." An examination of her history revealed that she was the only deaf child in a family of three children. She had attended three oral elementary schools for the deaf and two state residential schools for the deaf, and had been expelled from each one for her aggressive behavior. Following her expulsion from the last school, when only 16 years old, she was entered into the first of what was to turn out to be eight different rehabilitation centers. After brief periods in each one, she would be expelled for her aggressive behavior. Finally, she was placed in employment as an assembler of small parts. However, this employment terminated after only three months because of her interpersonal conflicts. Her parents, at the time of referral, were hopelessly discouraged and had almost totally rejected Carol. They were unable to use manual communication but, rather, insisted that she communicate orally. Carol could recognize only simple words through lipreading and

could not speak intelligibly at all. Thus, communication attempts involving Carol and her parents invariably led to explosive temper outbursts from Carol.

Testing information revealed that Carol was of dull normal intelligence but could read at the fourth-grade level, which was exceptionally high for a congenitally deaf person of her intelligence. Her manual dexterity was only fair. She could use manual communication fairly well, but rarely initiated a conversation. She was enrolled in work adjustment training in a sheltered workshop, provided with personal adjustment instruction by teachers who used manual communication, and given intensive counseling, which varied from one meeting per day to once per week. Carol progressed from work adjustment to vocational training, and, after 18 months, was finally graduated and placed in employment. She made dramatic progress during her training period, which was initially characterized by the same types of aggressive behavior that had led to her admission to the center. At one point early in her training program, she was seen by her counselor after she had taken her former boyfriend's coat and cut it into shreds. This is a portion of the counseling session:

Counselor: Your case manager told me you cut up your boyfriend's coat. Do you want to tell me why you did that?

Carol: (Shrugs shoulders and shakes her head slightly to indicate "No")

Counselor: (After a moderate pause) . . . You have been getting along real well for a long time, Carol. Your training instructor told me yesterday you were one of his best workers. And, your dormitory supervisor told me you were very good in the dormitory. This makes me a little surprised you would get angry enough to take scissors and cut up Bob's coat.

Carol: Who told you?

Counselor: Your case manager told me because she wants me to help you.

Carol: (Looks at counselor intently, then shifts around in her chair) . . . (Long pause) . . . He teased me . . . made fun me . . . has new girlfriend . . . I hate him . . . (without emotion on her face).

Counselor: You broke with him (counselor is aware of this from a previous interview), he has a new girlfriend, he teases you and you got mad him. That why you cut up his coat?

Carol: (Shakes head, "'Yes") . . . (Pause) . . . I hate him (with slight emotion on her face) . . . I hate him (with strong emotion) . . . (She begins to sob slowly, then more rapidly).

Counselor: (Silent, waiting while Carol cries).

Carol: (Cries bitterly for several minutes) . . . (Looks up at counselor after wiping tears out of her eyes and waits).

Counselor: Sorry you feel bad . . . I feel sad because you are not happy.

Carol: (Looks at counselor incredulously) . . . You feel sad? Why you feel sad?

Counselor: I feel sad because I like you. If you like another person and the person is hurt, then you feel sad too.

Carol: (Nods head slowly with understanding) . . . I have no friends. I never had friends. No one likes me.

Counselor: I like you. Mrs. Jones (case manager) likes you. Your teachers like you. Bob was your boyfriend for a long time, so he liked you. I think most people like you. But, you don't believe anyone likes you. Do you like yourself?

Carol: (Looks puzzled) Me like me? What you mean?

Counselor: You like some people because of how they act. You don't like some people if they do some things you don't like. People think about themselves, too. People like themselves, or they don't.

Carol: (Looks thoughtful) . . .

Counselor: Maybe you don't like yourself. Maybe you do some things so that other people won't like you, too. When you fight with someone, that makes them not like you. When you cut up Bob's coat, that made him not like you. If you like yourself, you will want to do things that will make other people like you.

Carol: Me mad easy. Can't help. Don't like mad. You mad sometime?

Counselor: Yes, I become cross sometimes, but when I become cross I show my cross(ness) by talking to the person I am cross with. I do not hit them, or tear up their clothes, because I know that not help(ful). If I hit a person, it makes more trouble and I hurt myself. If I talk about it with the person, we understand each other better and we solve our problem together . . . (Pause, while Carol looks thoughtful) . . . Maybe it is hard for you to talk about your cross(ness) . . . your feelings . . . because when you were young . . . little . . . you could not tell your mom and dad how you felt. Instead, you showed your feelings by throwing things at them, by hitting them, and they showed their feelings by spanking you a lot. Now you are grown up, but you still show your feelings by hitting people and by tearing up their things.

Carol: I should not hit people . . . tear up clothes . . . ? I should talk? How talk?

Counselor: Tell people how you feel. If you are cross, explain "I am cross," then tell them why, like "You teased me. I do not like it. Please stop." Then the other person will know how you feel. (Brief pause) Why don't we practice now? Tell me how you feel about Bob.

Carol: (Smiles shyly, self-consciously) About Bob? (Counselor nods) Me mad Bob . . . jealous (about) girlfriend . . . Bob said me dumb. Make me mad. Cut coat get even.

Counselor: Do you thing you could tell Bob that?

Carol: I don't know. I can talk Bob . . . tell sorry cut coat.

Counselor: Be sure to tell him why you cut his coat, also. I hope you will remember to tell other people how you feel. Don't hit them or tear up their things, because that will make you unhappy and it will make other people unhappy. Instead, tell them how you feel, and see what happens.

Carol: Okay. I will do.

Carol appeared to benefit extensively from this interview as well as from subsequent counseling sessions. She did not get into another fight during the remaining nine months of her training, nor did she destroy the property of others. In fact, she became an excellent student and managed to make many friends among the students with whom she came into contact.

Communication Deficiencies. Counseling with deaf clients is made more difficult because of communication problems than by any other factor. These problems or barriers are created by many factors, and are intensified when the counselor himself is limited in his ability to communicate in the manner preferred by the client.

Clients who do not speak or read lips well but who have a good command of language will be able to write back and forth with the counselor, although with most clients (and counselors!) this method detracts from interpersonal closeness and free emotional expression and slows down communication.

Some clients do not speak or speechread well enough to communicate with the counselor, and yet may lack the language that would permit them to write. Often these clients will be able to use manual communication, but there may be cases where only nonverbal communication is possible. At such times gestures, drawings, pantomime, and role playing should be used.

Manual communication (fingerspelling and sign language) is the communication modality preferred by and effective with most deaf clients, and every counselor who works with deaf clients should be proficient in

this form of communication. However, even this method has certain characteristics that may create less than optimum understanding. First, unless the counselor has a high degree of proficiency in manual communication, he will not be able to understand much of what the client says and may experience considerable frustration in laboriously spelling words that have no sign or trying to think of the appropriate sign for some words. It is not enough to be able to use manual communication rapidly; the counselor must also be able to use the terms and idiographic expressions peculiar to manual communication since the spontaneous use of manual communication by most deaf clients does not correspond to the syntax of the English language. Also, there are idioms in sign language just as there are in any language.

Thus, for some clients the counselor may use fingerspelling and signs as direct representations of English, but for others he must forget syntax and grammar, using the sign language in a way the deaf person can grasp.

One aspect of the communication problem is that deaf clients tend to omit verbs, tense, and qualifying adjectives. The counselor may thus have difficulty understanding whether the client is talking about the past, the present, or the future, and the depth of feeling experienced by the client may not be adequately expressed for lack of appropriate words. This problem may exist even when the client uses sign language, since signs generally do not indicate tense and one sign is frequently used for several different words. To illustrate briefly the ambiguities of sign language, the expressions "I feel . . ," "I felt . . ," and "I have felt . . ." are expressed the same way by many signers.

The counselor can do much to clarify the client's meaning by consistently responding in a manner designed to elicit an elaboration of thoughts and feelings. He should also check on the client's understanding by asking questions designed to stimulate responses to counselor comments.

Counseling requires almost continuous visual contact between the counselor and the deaf client. The client does not respond to speech through hearing, so he must either speechread or read the fingerspelling and/or signs of the counselor. In most cases, the counselor must either read the client's signs and fingerspelling or must try to speechread the client who uses speech since speech alone is frequently not fully understandable. This continuous visual contact is not present when the counselor works with hearing clients; there are frequent breaks in visual contact with much more stress placed upon auditory contact. Thus, some adjustments may be needed by the counselor who is not used to working with deaf clients. Generally, the counselor should pay close attention to what the client is saying,

but should avoid giving the impression of staring when there are lapses in communication. This can be accomplished by looking away slightly when the client appears to be uncomfortable, and then looking back either when he wishes to say something or when the client begins to sign or speak again.

The problem of constant visual contact will vary from client to client. Possibly the most trying period occurs when the client and counselor first begin to work together; as they get to know each other the problem should diminish. Some clients speak well enough so that the counselor may not need to speechread and may wish to look away at times when the client is speaking. However, it is not uncommon for the deaf client to interpret the counselor's looking away as an expression of disinterest or rejection.

The need for the counselor to be aware of the various possibilities for misunderstanding and confusion, and how these can be prevented, cannot be emphasized enough. Concentration on these aspects of the total counseling process may appear as an over concern with mechanics to the exclusion of the interpersonal relationship. Yet, genuine awareness of and concern for effective communication must include consideration of the many small things that go into it. These problems are very real and will not go away by ignoring them. Initially, attention to communication problems may reduce the counselor's awareness of other aspects of the client's behavior, but this attention will pay off as the client becomes aware that the counselor really does want to understand him.

An issue that is critical to the counselor's overall effectiveness is that of his philosophy toward communication with the client. The history of services for deaf people, most notably in the sphere of education, has been marked by an ideological battle over the relative merits of oral (speech and speechreading) methods and manual (fingerspelling and sign language) methods of communicating with the deaf. Proponents of each method have been emotional and subjective about their favored method and have tended to force the children and adults whom they serve to communicate using the method they think best for them. In almost all schools manual communication is not permitted with young deaf children in the classroom, and in some manual communication is forbidden for any child regardless of his age.

The counselor may encounter several problems because of the oral-only approach used in some schools. First, if he is employed in a school where manual communication is not permitted, he will be faced with the alternatives of forcing the client to avoid manual communication or permitting him to communicate as he wishes. Enforcing the use of oral communication with the client who does not wish to communicate in this man-

ner will destroy the counseling relationship since the element of threat will be present. However, by not forcing oral communication, the counselor will risk displeasing the school administrators and imperiling his job.

Second, the counselor may encounter a client who is intensely frustrated because he cannot communicate well orally but is forced to do so in the classroom. The counselor may (and should) feel obligated to point out to administrators and teachers the effects of this one-channel communication requirement on the child, but because of the "system" there may be little or no hope of change. The counselor will thus be faced with the task of helping his client adjust to an environment that is the direct cause of his problem.

Third, many parents of deaf children and young adults are threatened by the fact that their deaf child is "different," and overcompensate by having expectations that their child can be normal by learning to speak and speechread. In pursuing expertise in speech and speechreading for their child the parents may develop unrealistic goals that can only lead to frustration for everyone. To complicate the picture further, many professionals from education and medicine give false encouragement by invariably telling the parents the child can develop normal speech and speech comprehension if the child and parents will only work hard enough at it. The counselor who works with the children of such parents will be able to help the child most by helping the parents to work through their own feelings toward their child. In a school where oralism is rigorously enforced it will be difficult indeed for the counselor to work with such problems, however.

The following case is illustrative of some of the problems caused by inflexible communication approaches with the deaf individual. This particular case is also an example of a deaf person with excellent language and communication skills.

> Mary was a 27-year-old woman born with a severe hearing loss. When she was four years old her parents, noting that she did not respond to sounds other than loud noises, had her examined by an audiologist. The audiologist diagnosed the problem as one of serious loss of hearing, but told the parents that if she wore a hearing aid and attended public school, Mary would be "just like any other child." The parents were told that under no circumstances was Mary to be allowed to use sign language, for its use would destroy her chances for leading a normal life. The parents, being from an ethnic group that gave unswerving loyalty to the voice of authority (in this case, the audiologist), vowed to themselves that they would do everything in their power to see that their daughter grew up like "everybody else." To this end they had Mary fitted with a hearing aid, sent her to a preschool class for hearing-impaired children, talked to

her constantly without using sign language, and forbade her to have friends who used sign language. She soon enrolled in public school and, assimilating her parents' negative evaluation of deafness, tried every way within her power to appear as a "hearing person." In school she would sit in the front row and strain unceasingly to follow her teacher's speech through lipreading and what little residual hearing remained. In order to avoid the uncertainty and anxiety of having to communicate normally in a group of her peers, Mary would go home after school rather than join groups of her schoolmates in the school snackbar, at school activities, and the like. She went through junior and senior high school in this manner, barely managing to pass her courses and becoming something of a "loner." Following graduation from high school Mary went into her parents' business, helping out in a role that brought her into contact with people with whom she found it difficult to communicate. Many embarassing situations developed from her misunderstanding of comments and requests made by customers. Yet she continued at her parents' insistence. Later her mother died and her father, deeply affected by his wife's death, grew listless and despondent and gave the burden of the family business to Mary. Mary, struggling to keep the business going, made mistake after mistake with customers because of her deafness. Finally, out of frustration, she and her father sold the business and her father retired. Mary, then 22 years old, met and became friends with an audiologist who encouraged her to study toward her bachelor's degree in the education of the deaf. Encouraged by the first person who accepted her for what she was, she enrolled at a large state university and finally reached her senior year there. It was at this time that Mary came for counseling. She had struggled her way through semester after semester of courses having large groups of students and little close contact with the instructors. She finally entered the practicum courses in the teacher preparation program, and had to do practice teaching in public school with normally hearing children. By this time, however, Mary had developed a severe anxiety reaction. She was extremely nervous when talking to others. Her voice, soft and clearly understandable when she was with friends, would become harsh and strident when she was with people she did not know well or when she felt she was under pressure. She was also given to frequent periods of sleeplessness and despondence. Her college faculty adviser, who had a master's degree in education of the deaf, scolded her often for not trying to lipread better and for ostensibly using her deafness as a crutch. The audiologist who had advised Mary to attend college noted her tense state and suggested she seek counseling and tutoring in sign language. Interestingly, Mary made no progress in the manual communication class, and her teacher reported that she was not capable of learning the language.

When Mary came for her first counseling session she appeared extremely tense and ill at ease. She began speaking to the counselor, who

explained that he could not hear and that she would have to speak slowly and fingerspell and sign for him. Following is an excerpt from this first session:

Counselor: Mary, I cannot hear so you will have to speak slowly for me, or if you can sign that will help. We can also write if we find it necessary.

Mary: (Stuttering and having difficulty speaking) . . . I . . . I cannot sign. Maybe, may—be my teach—er told you I can't . . . learn to sign? (Smiles apologetically, swallowing with difficulty, and averts her head in painful self-consciousness).

Counselor: We won't worry about that right now. Let's just get to know each other a little better. I understand that you wanted to see me because you were having difficulty learning to use sign language. Can you explain a little about why you want to learn signs and just what problems you are having in learning?
(Note: The counselor spoke and used sign language simultaneously. Mary could understand him quite well through lipreading, but he intentionally used sign language to help her become accustomed to it.)

Mary: (Looking away, then returning her gaze to the counselor, painfully) . . . I . . . I don't know why . . . I can't learn. I am so nervous . . . (Looks distressed) . . . I am trying to learn because my speech teacher . . . thinks it will help my speech. But (hopelessly shaking her head) . . . I just can't seem to learn. My sign language teacher has spent a lot of time with me and says . . . she says I just can't learn to fingerspell.
(Note: Mary was speaking slowly and haltingly, obviously very anxious, but she would occasionally spell a word for the counselor in surprisingly good fingerspelling).

Counselor: One of the best ways to learn to use sign language is to practice with deaf people. Do you have any deaf friends or acquaintances, or do you ever practice in the classroom?

Mary: Oh, no! I do not know any deaf people. My parents did not want me to learn signs and would not let me bring home any deaf people who signed, so I have no one to practice with. (Here Mary had forgotten herself and was speaking and signing without hesitation.)

Counselor: That must have been hard on you. Do you communicate well with people who do not use sign language?

Mary: I can read lips quite well, and I can hear some. I do okay when a person is speaking directly to me, but in class and in groups I get lost.

The first session continued mostly in this manner. As it turned out, Mary could sign quite well when she relaxed, but she seldom relaxed with people who did not understand her hearing loss. Over the course of the next few sessions this was discussed with Mary, who admitted that her problem was that she would become nervous and panic-stricken in her sign language classes as well as in many other situations. Thus, what appeared as an inability to sign was actually acute anxiety and inability to function. Subsequent sessions revealed that Mary had an extremely negative self concept. She perceived deafness and anything associated with it (e.g., sign language) as undesirable, yet she was acutely conscious of the fact that she was deaf. She had spent years denying her deafness and putting on a false facade, as shown in the following exchange:

Counselor: You have difficulty following what is being said in a group, and yet you refuse to tell others you have a hearing loss. Why do you think you do like that?

Mary: (Shaking her head slowly) I . . . I . . . I just can't do it. With you I can be myself because I don't have to hide anything. You understand my problem, and you accept me as I am. I can't be this way with other people. It makes me so ashamed for others to know I am different.

Counselor: I am not sure I understand just what you mean, Mary. What I see in what you are saying is that I know what you are, and I accept you as you are, and your being what you are is still good. On the other hand, it seems you think if others knew what you are—deaf—they would see you as unworthy and would not accept you. This you could not stand. Is this true?

Mary: (Thinking for a few moments) . . . I think that is it. I know my deafness means nothing to you, but with others I feel it means everything. I just can't stand for others to know. I know, really, that deafness is not that bad, but I can't help feeling this way. I have thought and thought about it and I know I am being silly, but that doesn't change how I feel.

Counselor: I believe I can understand how you feel, Mary. Your feelings about your deafness are a part of you, and although you know consciously that your deafness is something that is not your fault, you can't help being ashamed. (Pause) . . . Can you tell me whether the rejection—or negative feelings—you perceive in others could possibly be your own feelings toward yourself, rather than real feelings people have toward your deafness?

Mary: (Appearing shocked). You mean other people don't see me as bad, that the feelings I see in others are really my own feelings? (Becoming angry now).

Counselor: I see this idea is upsetting you. Can you help me understand why it bothers you?

Mary: (With some hostility) . . . Yes! It does bother me! I am not imagining things. You make me feel like you don't believe me! You make me feel like it is all my fault, like my adviser said.

Counselor: I can see that this really bothers you, so there must be something important in what we are saying. But, I did not say that it was your fault. I said only that perhaps the bad feelings you have about having others know about your deafness actually reflect some of your own attitudes toward deafness. In other words, you see deafness making you unworthy . . . inferior . . . and you think others feel the same way.

Mary: (Looking shaken) . . . I . . . I can . . . hardly believe what you are saying. But it hurts . . . you are right . . . I hate myself (begins to cry brokenly).

This was the turning point for Mary, who had absorbed her parent's devaluation of her deafness and who had for years carried the heavy burden imposed upon those who try to be what they are not. In subsequent interviews Mary became more and more aware of her own attitudes toward deafness. She came to understand that she was equating her deafness with her entire being, and rejecting herself as a person just as she rejected her deafness. With this realization and through social interaction with other deaf adults, Mary was slowly able to work through the negative feelings she had accumulated toward herself and her hearing loss. At the termination of counseling, Mary had learned to use manual communication very well, was more relaxed with others, readily mentioned her hearing loss when she could not understand someone, was going steady with a deaf man, and had obtained a job as a teacher of young children in a school for the deaf. Everything was not rosy, however; Mary still experienced periods of anxiety and self-doubt. The roots of self-rejection, planted in childhood, are not so easily uprooted. Perhaps this is a lesson for those who would deny a deaf child any method of communication, or not permit him to make effective adjustments in life as a *deaf* person rather than as a poor facsimile of a hearing person.

It should be obvious to the counselor that there is no place for personal bias as far as methods of communication are concerned. It is a basic tenet of all counseling approaches that the client be permitted to be himself in the counseling interview. With deaf clients, this includes allowing them the freedom to express themselves as they feel most comfortable.

In rehabilitation settings and in private practice there is generally little difficulty with the issue of communication methods since (*a*) the emphasis is upon practical adjustment to one's problems, and (*b*) parents of adult

deaf people and problem children are more receptive to all methods of communication. However, the counselor who functions in a school setting that by policy or practice excludes manual communication (no school excludes oral communication) will experience real conflict. He can either subscribe to the oralism only philosophy, which is incongruent with the concept of unconditional acceptance, or he can disregard policy and encourage the client to communicate as he feels most comfortable. But the counselor who forces a method of communication upon a client does so at the risk of doing serious damage to his effectiveness in the helping relationship.

We know of no analogy to this communication methods issue as far as counseling with hearing clients is concerned. It would be inconceivable for a counselor to force a disturbed hearing individual to avoid using bodily gestures. Yet, there are counselors who do not permit their deaf clients to use manual communication. It is interesting to note that psychiatric research has suggested that to force a client to speak in a language he is not fully comfortable with increases defenses and conceals problems.

Another consideration for the counselor to keep in mind is that the leading causes of deafness are also etiologies of neurological disorders, and especially brain damage. This means that a significant number of deaf people will be further handicapped by neurological deficits that may impede perception and learning and contribute to behavioral pathology. Thus, change in such clients through counseling may be considerably slower and more difficult than normal considering their apparent problems. This indicates that the counselor should take care not to interpret slow change or failure to change simply as manifestations of personality or character deficiences.

Communication skills will be much more restricted in young deaf children because more often than not they enter school with practically no language, speech, or manual communication skills. Such children usually have an extremely limited vocabulary if any at all. As a consequence, they are generally unable to make all their needs known and have no practical way to communicate verbally.

The counselor with young deaf children will need to encourage them through psychodrama, play therapy, and pantomime. Drawing, in water colors, crayons, and pencil, is another way of communicating with deaf children. The counselor should use speech and manual communication as he works with the deaf child. Through these efforts the child will slowly develop better ability to communicate with the counselor as well as others.

A large number of deaf adults who have been isolated within their

families and kept out of school will present special communication problems to the counselor. These deaf people will generally have no speech, no speechreading ability, no writing ability, little knowledge of sign language, and little language upon which they can base any of these communication methods. Effective counseling is unbelievably difficult with these individuals, but the use of psychodrama, pantomime, drawing, painting, and pictures will enable most of them to achieve some degree of emotional expression and realize more of their potentials. Outside of counseling per se, these people derive great emotional benefits from recreational activities and work experience. At times the counselor will need to assist the client to become involved in these activities.

There are instances where the counselor may talk with the client in the presence of his parents or others who play a significant role in his life. In such cases, the counselor should make a point of explaining, for the benefit of the deaf client, remarks made by the parents or others, regardless of their nature. Otherwise, the client may perceive the counselor in the same light as those who have always excluded him.

A final point to be made concerns the counselor's use of the telephone. The hearing client can at least hear the counselor's remarks whenever a telephone call interrupts an interview, but the deaf client is completely excluded from the counselor's life while he is on the phone. To avoid such a situation, which can arouse hostility in a deaf client, the counselor should avoid accepting telephone calls during interviews. This may appear to be a small point, but it should be remembered that the telephone can represent to the deaf client a symbol of his inability to cope with his world.

Developmental and Experiential Limitations. Deafness per se is a decided handicap to the individual in his functioning in a setting where spoken communication is used. However, outside of its impact on interpersonal communication and its restricting influence on some activities requiring hearing (as, for example, listening to a radio) deafness does not necessarily create development or adjustment problems. Rather, it is the people in the deaf person's world, through omission or commission, who impose limitations on him. Because most people know so little about deafness and how to communicate with deaf people, a host of adjustment problems are created.

It is not the purpose of this chapter to deal with the adjustment problems related to deafness. However, it is important to point out that deafness often isolates the deaf person within the family circle, cuts him off from free interaction with his peers, restricts the input of information from the world about him, curtails learning of behavior that will permit inde-

pendence as an adult, and makes his ability to adjust to his world significantly less. The net result may often be that the individual is dependent in his behavior to an extent out of proportion to the degree of psychological disturbance present.

These facts have important implications for the counselor. Although information-giving is admittedly not counseling, in the absence of other helping persons the counselor frequently must provide information of different kinds to his client. In a sense, such information-giving is basic to effective counseling since many clients lack information that makes successful counseling possible. For example, with the client who feels that hearing people talk about him at work, it is not enough to deal only with his feelings about the situation. An explanation to the effect that deafness is rather unusual and that others sometimes react against someone they do not understand is as useful and important as trying to help the client to deal with his hostile feelings.

Another point is that many clients will be dependent upon the counselor and will often look to him for immediate, sometimes "magical" solutions to their problems. Overcoming dependency and unrealistic expectations requires that the counselor help the client to understand the purpose of counseling, the responsibilities of the counselor and the client, and how the two can work together to achieve their goals. This is not to imply this can be accomplished in a preliminary interview or even over a brief period of time; rather the counselor must be prepared to repeatedly explain and clarify what is happening in counseling and why.

The dependency of many deaf people is often not of the type characteristic of individuals who are emotionally dependent upon others. Rather, this dependency is engendered by the fact that the deaf individual has a more restricted range of experience to guide him in his behavior, has had fewer opportunities to make decisions on his own, and has generally had others help him most of his life. This can be contrasted with the type of dependency that is created by early disturbed interpersonal relationships and the resulting emotional insecurity. This point is important in that the experientially deprived client's potential for growing toward independence will be greater than it would be if there were long-standing emotional dependency. The counselor, by recognizing this, can provide information the client needs to become more independent and can encourage him to participate in activities that will provide him with a broader range of experiences and behavior patterns.

The fact that deafness often results in disturbed relationships between the individual and others in his life who can hear may lead him to fear

and/or distrust hearing people in general. This is understandable, but what concerns us is that this may present a special problem for the hearing counselor who works with deaf people. The deaf client may fear and distrust the hearing counselor because he represents a threat. Yet, on the other hand, the deaf person may think that deafness makes one inferior, that a deaf counselor is inferior and less worthy, and that a deaf counselor cannot be of help. If the counselor observes such feelings, by talking about them with the client the latter will have a chance to become more aware of his feelings and will be in a better position to deal with them.

The fact of limited experience and underdeveloped interpersonal skills underscores the need for the counselor to assist the client to become involved in activities that will increase his knowledge and skills in relating to people. This means, again, going outside of counseling per se and becoming concerned to some extent with the client's daily activities. This does not imply that the counselor takes the client by the hand and goes with him; rather, it means that the counselor should find out some of the things the client is doing in his work life, in his personal life, and in his social life and help to direct him into activities that will provide rewarding experiences and knowledge.

Issues in Counseling with Deaf Clients

The discussion thus far has dealt with the deaf client, his limitations and assets, and how the counselor can reduce the impact of the communication barrier in counseling with him. However, there are also other issues that relate more to factors outside the client. These include client expectations of counseling, situational barriers, the use of tests, information-giving, confidentiality and privacy, the appropriateness of various counseling approaches, the values of counseling, and administrative support of counseling activities.

Client Expectations. Counselors are well aware that many clients have misconceptions about counseling and the healing powers of the counselor. However, the concept of counseling as a helping relationship is fostered in hearing people by the fact that many schools have guidance programs, mental health concepts are taught in the school, there exist many counseling agencies in the community, people talk about being helped by counseling, there are television programs having plots built around psychiatry, and there are movies with themes including counseling.

With deaf individuals, problems associated with expectations concerning counseling appear to be greater. Many schools for the deaf do not have a counseling and guidance program. Many of those that do are frequently

either staffed with an individual whose main responsibility is psychometric testing or discipline or with professionals who have very little knowledge of the problems of deaf people and almost no competency in the use of manual communication. Rare is the school that has an active counseling and guidance program staffed with individuals who are professionally trained as counselors, knowledgeable and experienced in the field of deafness, and fluent in the use of manual communication. In addition, supervisors of dormitories in schools for the deaf are most often called "counselors." The great majority of these people have had no formal training and must function to keep order and discipline rather than provide counseling. Thus, at the present time it can be expected that most deaf clients have gone through a school that has no counseling program or has one in name only. This fact has a negative impact on deaf youth insofar as the image of counseling is concerned.

Another difficulty is that all too often students in schools for the deaf are referred for counseling only when there is a behavior problem involved. Seldom is the quiet child, or the one who has problems but does not manifest them in behavioral disorders, referred for counseling. Nor is counseling seen as a part of total education for all children. Thus, in too many minds counseling is for "bad" boys and girls.

Few deaf people appear to come for counseling on a voluntary basis. Most often they are referred by an agency or school staff member, family member, or interested individual. Counseling for adults is usually paid for by an agency such as Vocational Rehabilitation, by the individual's family, or through a reduced fee plan such as that provided through a family service agency. Only a very few deaf people earn enough to afford the relatively high fee charged for individual counseling.

These facts create special difficulties insofar as client expectations of counseling are concerned. Most deaf clients come to the counselor with practically no idea of what can be accomplished and how; quite a few come with the idea that their problems can be resolved in one or two interviews. Some even come with the idea that the counselor will analyze them and tell the referring agency all about them.

The counselor must be aware of the circumstances that bring deaf people to counseling and help them to understand as well as possible what the counseling process will involve. The client should be reassured of the privacy and confidentiality of interview contents or informed beforehand if a report must be given to a referring agency.

Finally, a number of deaf clients will come for counseling with the feeling that the counselor will do everything for them, and they will then

be fine. There are many hearing clients like this, but with deaf clients this view is based largely on the fact that the staff in schools for the deaf often have a rather paternalistic attitude and far too many things are done for the deaf child that he could and should do for himself. Regimentation is the rule in many schools, and this no doubt fosters a passivity that is manifested in the attitude that everything will be done for the deaf person.

Situational Barriers. Deaf people generally encounter relatively greater difficulties in their world than do hearing people. These difficulties begin in childhood and continue through adulthood. Beginning with a limitation or lack of parental understanding and communication in childhood, the deaf individual progresses through his developmental years encountering difficulties in communicating with others, in learning about himself and his world, in coping with educational, personal, and social situations, and in entering and functioning in the world of work. Aside from the communication barrier per se, barriers to successful work adjustment and career advancement often exist because of negative attitudes of employers and fellow employees.

These situational barriers have their roots in antiquity. The early Greeks took handicapped children away and left them for animals to devour; Aristotle viewed the deaf as being uneducable; early Spain viewed the deaf as eternal children unless they learned to speak; early England and Colonial America implied their views of the deaf by naming their first schools for the deaf "asylums." In Biblical times the deaf, the blind, and the maimed were the afflicted; only divine intervention could save them. Thus, down through the years there have been various devaluing attitudes toward deaf people, and even today they are seen as less capable. Obviously, such attitudes work against the deaf person in social interaction, in employment, and in community participation.

These points are raised because frequently a deaf client will bring to counseling a very real situational problem that the unknowledgeable counselor may view as a symptom of pathology. If the deaf client complains that he is discriminated against in his job, chances are there is some truth in it. If he feels that his co-workers sometimes laugh at him and talk about him, the fact is that such is not an uncommon occurence. If he states that he feels uncomfortable and anxious when meeting new hearing people at a social gathering, he is certainly not alone, for most people with a serious communication handicap such as deafness have a difficult and often embarrassing time meeting new people who do not know how to talk with a deaf person.

These facts have several implications for the counselor. First, there is

a wide variety of situational barriers faced by the deaf that are decidedly not common for those who hear. The counselor must understand these barriers and their impact on the client before he can hope to understand the client's thoughts and feelings about them.

Second, the counselor must have some insight into how other deaf people have successfully overcome these barriers. If he has this knowledge, he will be in a better position to help the deaf client understand how he can deal with special situations as well as his feelings about them. The way a hearing person deals with certain problems may be totally ineffective for a deaf person.

Third, the counselor must be aware of those situations that are almost impossible to change and must help the deaf client to understand and accept his limitations. A case in point is the deaf client who has grown up with the idea that if he will only try hard enough he will be able to speak normally and understand the speech of everyone through speechreading. Because he finds he cannot, which inevitably he must, he develops guilt feelings and blames himself for not trying hard enough. The counselor who understands that no person who has been deaf most of his life can speak normally and who knows that no deaf person can speechread all people equally well in all situations can help the client to achieve a more realistic understanding of his own capabilities and a better self-acceptance.

Attitudes of family members toward deafness may represent another very real situational barrier for the deaf person. Very few medical doctors possess an understanding of deafness adequate for providing proper guidance to parents of deaf children. In many instances parents are given false hope that their child can be "normal" by learning to speak and read lips. Even some professionals who should know better—audiologists, otologists, and quite a few educators of the deaf—may provide false encouragement to some parents. Thus, these parents may have misconceptions about the deaf child and may foster emotional difficulties by their unrealistic expectations. The counselor must be aware of the capabilities of deaf children, youth, and adults, must understand parental attitudes, and must be able to help parents develop the proper perspective concerning their deaf child.

The concept that the deaf child is punishment for one's sins is not uncommon among parents (and their neighbors!). Many parents may experience conscious or unconscious guilt feelings because of this, which may lead to either rejection or overprotection of the deaf child. The counselor must be aware of this possibility and be able to help parents understand their feelings and actions, as well as help the deaf client to understand the behavior of his parents.

The Use of Tests. Test results can be of considerable benefit to deaf clients. In addition to providing information that can be used to help in making important educational, career, and personal decisions, test results can often provide the client with information about himself that will lead to greater self-understanding and self-acceptance. These benefits can be considered as especially important to deaf clients, who generally lack knowledge about their own abilities and who may be less aware of the factors that are required for effective achievement in school or on the job.

However, there are specific problems that make the use of test information difficult with deaf clients. First, language limitations may preclude the use of tests that are highly verbal in content. For example, most group intelligence tests, verbal intelligence tests such as the Verbal Scale of the Wechsler Adult Intelligence Scale and the Stanford-Binet Intelligence Scale, the Strong Vocational Interest Blank, the Minnesota Multiphasic Personality Inventory, and other paper and pencil personality inventories will generally yield an inadequate and distorted picture of the deaf client, because he will not accurately understand many if not most of the test items.

Second, most personality inventories contain a number of items or statements that will produce an inaccurate assessment of the deaf individual. Specifically, some inventory items couched in too nebulous and dubious terms will be related to pathology in a hearing individual, but will be related to normalcy in a deaf person.

Third, the valid administration of a test to deaf persons requires that they understand the directions for the test. These directions frequently require more reading ability than the client possesses, or directions are given orally in a manner the client may fail to understand. Thus, the client may make mistakes simply for lack of understanding what is expected of him.

Finally, and perhaps most importantly, it is often difficult to explain test results to the client in a manner that will permit him to make meaningful use of such information. Again, this difficulty is related to the communication (language) problems of the client. The experienced counselor will find this less of a problem than the inexperienced one.

It must be emphasized that these problems will not be present for all deaf clients. However, they will exist with many, and for some of them tests can do no more than give a *very rough approximation* of the client's abilities and limitations. With a significant number of deaf clients only the nonverbal, performance-type tests will yield meaningful information, and it will be next to impossible to fully explain the results.

Counselors should become familiar with the subject of psychological evaluation of deaf people and be aware of the strengths and limitations of

current tests. Vernon (1967a) has presented an excellent paper on this subject, which should be read by all counselors with the deaf.

In interpreting test results, it is axiomatic that the counselor must try to explain the meaning of such information in terms the deaf client can understand. This means concreteness and specificity, with as many examples as the counselor can think of, and the client should be asked to respond to the counselor's explanation so that his understanding can be checked.

Information-Giving. We have pointed out that information-giving is not counseling, but we recognize also that the provision of information to deaf clients who need and desire it can be a useful part of the counseling process. The counselor may often find that his deaf clients lack a great deal of information about themselves and their world, and in the absence of other helping persons who might provide this the counselor can help the client to obtain the information he is seeking.

It is important to understand the great need for information among deaf people. Considering their language handicap, the isolation they experience within the family circle as well as in the community, and the fact that they do not absorb information coming from many sources readily accessible to those with hearing (e.g., radio, television, casual conversation with family and friends), it is logical that they learn much less about themselves and their world than the hearing individual with similar potentials. Ironically, too, they are less able to make use of information that has been specifically prepared for guidance purposes because such information is usually presented in brochures and other literature that is difficult for the deaf person to read and understand.

The need of deaf clients for information exists at all levels, from early childhood through adulthood. The young deaf child experiencing difficulty adjusting to his family or to school may often lack even rudimentary language skills; he may not even know the names of common objects, let alone language that can be used for emotional expression. With the progression of the child through school he will generally acquire more and more language, but usually his language will not be at a level that will permit him to deal fully with the developmental needs that occur at his age level. Many deaf adults will continue to encounter frustrations with language because adulthood requires communication skills that they simply do not have. Objective evidence of this is available from a study of the academic achievement test performance of hearing-impaired students in the United States (Office of Demographic Studies, Gallaudet College, 1969), which found that (1) the average 19-year-old deaf student in

schools and classes for hearing-impaired children has achieved a 5.6 grade equivalent score on the Paragraph Meaning subtest of the Stanford Achievement Test Advanced Battery, and (2) the difference between 7-year-old hearing-impaired children and 19-year-old hearing impaired youth in terms of grade level scores on the Paragraph Meaning subtest is only 4.0, which suggests that deaf students advance only four years in reading ability over a period of 12 years!

Reading ability in deaf clients is a critical factor since most of the information they acquire must come from reading. Auditory avenues of learning are closed to them. And yet, the reading ability of most deaf adults is such they cannot adequately understand a typical newspaper article.

Thus, the counselor who works with deaf clients must expect them to generally lack important information and must be prepared to help them acquire information through various approaches. One obstacle to achieving this is the shortage of prepared materials that the client himself can use. Counseling has always been a neglected aspect of the education and rehabilitation of the deaf. One consequence has been that materials and techniques for disseminating information to deaf clients are quite limited. Presently available guidance materials emphasize verbal information, in the form of brochures, descriptive printouts, books, and films or movies with sound that is basic to understanding content. The result is that these materials are of limited applicability with deaf people.

The practicing counselor is nevertheless faced with the task of imparting occupational information as well as other types of information. It is not uncommon for the conscientious counselor to take available guidance materials and go over them with the client so as to assure proper understanding. This approach is frustrating because of the time element and the dependence on the counselor it fosters. Yet, for lack of adequate materials it is often the only means available to ensure that the client obtains the type of knowledge he needs. In a school setting, group guidance as well as field trips and actual exposure to structured learning situations offer productive ways in which clients can acquire information, but in individual counseling with deaf adults the counselor's time limitations may largely preclude the use of the latter. In such cases the counselor will need to depend upon the interview as a medium through which he can impart information to the client.

The counselor can permit counseling sessions to be reduced to information-giving sessions. This must be kept in mind and avoided if he is to carry out his primary role, which is to provide the conditions that facilitate constructive personality growth. Yet, the counselor must accept some

responsibility for helping the client to learn many of the small but important things about himself and his world that he has failed to learn through his own resources. This is necessary due to the shortage of other helping persons to whom such responsibility can be assigned. It should be stressed, however, that whatever the counselor does in providing information should be done in such a way that the client participates fully in the information acquiring process, and in the process learns problem-solving skills that he himself can use in the future.

Confidentiality and Privacy. The need of the deaf client for privacy and confidentiality is as great or greater than this need with other clients. The impact of deafness is such that deaf people—children as well as adults—seek out others like themselves for social and recreational purposes. One consequence of this closeness is that they know what others like themselves are doing and have done in the past. While this may be advantageous in some respects, it is disadvantageous in the sense that the individual may have little if any privacy and may often conceal many of his thoughts and feelings for fear of exposure to and rejection by peers. In addition to leading to a certain degree of superficiality in one's relations with others in the group, this concealment of thoughts and feelings may make it difficult for the client to be open with the counselor from habit or from fear that the counselor will reveal what he learns in the counseling interview.

The client's fear is more often than not founded on actual experience with teachers and counselors. Staff members at schools for the deaf spend long hours with students, work with them daily for many years, and like the students themselves, may become part of the "family." One teacher may talk about the students in a negative way, and others may pass this along until it gets back to the student that the teacher is talking about him. Then, too, some guidance programs provide for staff meetings involving teachers and other staff members where individual students are discussed. At such meetings the counselor may present a report on a student that disregards the confidential nature of the counselor-client relationship and all too often this fact gets back to the client and his trust is destroyed.

The counselor can safeguard the privacy of the counseling relationship in school settings by helping the administration, teachers, dormitory houseparents, and others to understand the nature of this relationship and the need for confidentiality. In instances where the welfare of the client is best served by sharing information gained from him, it is vital that his approval first be obtained.

In rehabilitation settings as well as private practice it is often the case that the deaf client is referred and financially sponsored by a State Voca-

tional Rehabilitation agency, which requires periodic progress reports from the counselor. In such cases the counselor should explain to the client about the need for the reports and obtain approval and permission to make them.

The counselor who is deaf may frequently encounter a unique, and at times frustrating, problem with confidentiality. Being deaf himself and faced with some of the same communication problems experienced by other deaf people, he naturally turns to the deaf community for much of his social satisfaction. This will bring him into social contact with his clients as well as potential clients, and the fact of this social interaction may threaten the client's confidence that the counselor will maintain the privacy and confidentiality of the interview (Stewart, 1967). The counselor's ability (or lack of it!) to maintain confidentiality will eventually become known among deaf people, which will establish his reputation. If the counselor for any reason should discuss client problems indiscretely it can do great harm not only to the client but to the counselor as well because the members of the deaf community are relatively close and word travels fast among them.

Applicability of Different Counseling Methods with Deaf Persons. The discipline of counseling encompasses a large number of treatment approaches based upon related theories of personality and learning. These approaches range from Freudian psychoanalysis, which stresses the role of the unconscious and the lifting of repressions, to client-centered counseling, which is less technique-oriented and which focuses upon the relationship between the client and the counselor. In considering the subject of counseling with deaf people it is logical to raise the question of which of the existing counseling approaches are applicable with deaf clients.

Counseling with deaf people up to the present time has remained a relatively unexplored area because of the small number of counselors and because few practicing counselors have reported on their experiences with deaf individuals. The research that has been reported has involved primarily deaf inpatients in mental hospitals (Rainer, et al., 1963; Rainer and Altshuler, 1966; Grinker, 1969), and because of the theoretical orientation of most practitioners in medical settings these research reports have dealt primarily with the application of essentially psychoanalytic principles. Thus, at the present time there is relatively little information on which counseling approaches can be used with deaf clients.

Despite this lack of research in counseling the deaf, available information suggests the hypothesis that the less verbal and less abstract counseling approaches are more appropriate for the majority of deaf clients, whereas the more verbal and abstract approaches can be used only with those who

possess normal or exceptional verbal skills. For example, Goetzinger (1967) and Vernon (1967c) suggest that an eclectic approach using basically directive techniques is most effective with deaf clients. Several other writers appear to share this view, stressing that the development of insight in deaf clients is very difficult because of their language and conceptual limitations (Rainer, et al., 1963; Rainer and Altschuler, 1966; Grinker, 1969).

To summarize, the present state of knowledge concerning the applicability of various approaches in counseling with deaf clients does not permit us to draw meaningful conclusions other than that the approaches which require a high degree of abstract thinking and extensive verbal interaction between the counselor and the client will in most cases be of limited applicability. However, this fact may not be as limiting as it may at first appear, since evidence from counseling hearing persons suggests strongly that it is the relationship between the counselor and the client that is the agent of personality change rather than the method or techniques used by the counselor.

Counseling Outcomes and Administrative Support of Counseling. An important issue, which has received no attention in the literature, is that of the value of counseling programs as perceived by administrators in schools for the deaf. Counseling as we conceptualize it is a relative newcomer to the educational scene in schools for the deaf. Few educators appear to see counseling as anything other than psychometric testing, the provision of occupational information, and "something" done for children who have behavior problems. This may be due to the counselor's failure to help other staff members understand the purpose of counseling, the fact that many of the positive outcomes of counseling are not readily observable to those who have only brief or superficial contacts with students, and the fact that many educators do not understand human motivation and behavior well enough to appreciate the difficulty in changing a client's behavior in a short time.

Our society or culture is outcome-oriented in the sense that we seek concrete evidence of the end product of our work. In education this is manifested in the traditional use of classroom tests as well as achievement tests administered once or twice during the school year. Classroom instruction has specific objectives, procedures, content, and evaluation criteria, and because of these teachers and administrators have some means for understanding what must be done and how results of efforts can be measured. The student who advances from 5.2 to 6.1 in reading ability on an achievement test during a year's time gives concrete evidence of progress, regard-

less of questions that could be raised concerning how he might have done without a teacher, the use of a different instructional approach, and even the possible impact of a different teacher. In counseling, however, there are no specific subjects to be "taught" to all clients; counseling "content" does not remain the same from year to year with a curriculum that can be revised and updated periodically; there are no reliable and valid "behavior achievement tests" that yield meaningful achievement scores that the counselor and administrator can point to with pride and use to justify additional funding for more counselors, counseling materials, and counseling rooms.

Instead, the counseling interview is conducted in privacy; teachers and administrators cannot visit the counseling office and view the counseling process in action. It is no small wonder that others may question the value of the work of the counselor who has clients with tremendously different problems and needs, because they do not know what it is the counselor does and what happens as a result of his efforts.

To make matters worse, many counselors attempt to explain their work in terms they know and appreciate, but which no one else may understand. For example, the concepts of self-understanding and self-acceptance are commonly understood among counselors, but this understanding is not always shared by the busy administrator or teacher who wants to see the student cease his disruptive behavior. Then, too, some counselors may be so concerned with maintaining confidentiality they refuse to say anything to others. While this may protect the counselor-client relationship, it does not contribute to the acceptance and support of the counselor's work by other staff members.

The counselor with deaf people will encounter these problems, which are shared by counselors with other clients. It is important that he understand why these problems exist and do as much as he can to help other staff members understand his work and how it contributes to their mutual goal of helping the individual student toward the fulfillment of his potentials.

Conclusion

It is quite clear that we do not know as much as we should at this time about counseling deaf people. Yet, a growing commitment to this vital force in the lives of deaf people will ensure that our knowledge will increase rapidly in the future. Only as the field of counseling the deaf evaluates itself can it grow and expand in a meaningful manner. And only as the coun-

selor becomes a valued member of the team—whether it be in education or in rehabilitation—can he make his maximum contribution.

Summary

This chapter began with a discussion of the nature of counseling. Some common misconceptions of counseling were pointed out, followed by a definition of counseling in terms of general characteristics, and in terms of more specific characteristics, including those which differentiate counseling from the relationships such as interviewing. The core conditions that must be offered by a counselor include a deep respect for the client, empathic understanding, and genuineness.

The implementation of these conditions by the counselor in the counseling relationship was discussed, and the client's major responsibility and activity in the counseling relationship, the process of self-exploration, was pointed out.

This was followed by a consideration of the application of basic principles in counseling with deaf people. Some general principles of this application were noted, including assumptions of the counselor about deaf clients. Characteristics of deaf clients that are obstacles to counseling were noted. These include language limitations, conceptual limitations, communication deficiencies, and developmental and experiential limitations. Some common issues in counseling with deaf clients were noted, such as client expectations, situational barriers, the use of tests, information-giving, confidentiality and privacy, applicability of different counseling methods, and administrative support of counseling as related to desirable counseling outcomes.

CHAPTER IV

Role and Function of the Counselor

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Introduction

The counseling profession has made little inroad into the area of deafness—in contrast to counseling with other client groups. The authors of this chapter will outline the professionalization of the counselor, delineating role and function and extrapolating to the specifics of counseling with the deaf person. It is divided into two sections. Section one will deal with the role and functions of the counselor covering general principles of counseling that are applicable to all professional counselors. It refers to rehabilitation counseling for illustrations of paradoxes and problems in the emergence of the professional counselor and his role and functions. Section two will translate the general principles of counseling into the specifics of counseling with deaf persons. Both authors affirm the applicability of general counseling to counseling the deaf person. Both recognize the complexity of the problem of counseling the deaf and the urgency of initiating a broad base of professional concern and action to develop effective programs of professional counseling services for the deaf person.

The Counselor's Role and Function

The profession of counseling is reality bound. The humanistic philosophy that undergirds democracy in America has been translated into concrete expressions of caring for the dignity of man through a wide array of private, public, local, state, and federal programs of counseling. These programs have focused upon facilitating and maximizing human resources.

Programs of counseling services may be found in public and private rehabilitation agencies, elementary, secondary, and higher institutions of education, divisions of mental health, institutions for the mentally retarded, and a variety of other community agencies. The ultimate goal of such programs of counseling services is to foster the optimal adaptation of the person in significant areas of living—the catalyzing of his human development. Since counseling services are provided to a client within the framework of ongoing programs of educational, vocational, medical, social, and psychological services, one must first look at some of the realities of human service programs to understand counselor role and function.

There has been a swelling tide of federal legislation that has designated for counseling a broadened and fundamental role in meeting human needs and solving problems of persons in a variety of life situations.

A basic tenet of such programs is that helping people progress in education and engage in productive work requires the service of a professional counselor. Specific federal legislation creating a demand for counseling services includes: the Manpower Development and Training Act, the Economic Opportunity Act, the Vocational Education Act, amendments to the National Defense Education Act, amendments to the Vocational Rehabilitation Act, the Elementary and Secondary Education Act, and Manpower legislation. The counseling profession is turned to as the appropriate deliverer of a unique kind of person-services to ameliorate social problems.

The chronology of vocational rehabilitation in its programs of services to persons with physicial and mental handicaps toward employment documents the development of the counseling profession and the forces that have influenced counselor role and functions. Counseling services in embryonic form were seen in vocational rehabilitation service program with the passage of the Vocational Rehabilitation Act for civilians in 1920. Legislation during the 1930s, early 1940s, post-World War II, and in the mid-1950s progressively extended the field of vocational rehabilitation, eventuating in the present-day large-scale state-federal program in vocational rehabilitation. The 1954 Vocational Rehabilitation amendments, (Public Law 565), which authorized professional training of counselors, led to concern about training and practice. These relate to the professionalization of rehabilitation counseling. Specification of these standards for training and practice and job tasks was asked of the counseling profession.

Without guidelines, the first rehabilitation counselors were overseers of the rehabilitation process—intelligent, educated persons of good appearance and character who liked working in people programs. Such rehabilita-

tion counselors were the first coordinators of rehabilitation services. But with the authorization for training of rehabilitation counselors came guidelines and professional standards for rehabilitation counseling.

Graduate training programs in rehabilitation counseling sponsored by the Rehabilitation Services Administration are now predicated upon these professional standards for training as requisites for entry into the practice of rehabilitation counseling.

Emergence of Professional Counseling

Rehabilitation counseling literature in the 1950s documents the development of counseling in rehabilitation agencies. A number of authors described the lack of clarity in role and functions of counselors. These articles provided theoretical speculation on such topics as: "Counselor versus coordinator"; "Counselor as jack-of-all-trades"; "Counselor as team captain"; "Counselor as psychologist", etc.

While the functions of the rehabilitation counselor are all geared to meet the needs of the handicapped client, delineation of his basic duties is complicated by the variety of task functions in rehabilitation agencies. This exemplifies the age-old conflict between professional training standards and practical demands in the field. Nonetheless, such delineation is essential in order to supply adequately trained professional counselors in numbers sufficient for the counseling needs of rehabilitation clients. And the differentiation and specification of role and functions is necessary to delineate the area of professional counseling practice from that of allied professional or "support" personnel now coming into wide use in vocational rehabilitation.

The conflicting roles and the variety of functions demanded of the rehabilitation counselor make delineation of role functions a delicate task.

In discussing the role conceptualization of rehabilitation counseling, Patterson (1957) saw four possible alternatives to the choice of counselor or coordinator: To consider the counselor primarily as a coordinator and train him for this function; to train an individual for both functions; to concentrate on the training of competent counselors in the available time; and to think of counselors *and* coordinators, not counselor *or* coordinators.

McGowan (1960, 1967) in two training manuals for the orientation and in-service training of rehabilitation counselors describes the necessary skills, knowledge, and duties of the rehabilitation counselor. A summary of these is still a demanding list.

Included are skills ranging from the ability to establish and maintain a counseling relationship to utilizing community resources and functioning in a public-relations role. Basic knowledge required includes a spectrum

from human behavior as it relates to personal, social, and vocational adjustment, to local, state, and federal laws relating to rehabilitation and local employment policies. Necessary duties include collecting information for evaluation, diagnosis, and integrating it into a sound plan for rehabilitation and arranging for services and follow-up.

Job descriptions published by state personnel boards for rehabilitation counselors confirm this wide variety of skills, knowledge, and duties. This wide variety also lends itself readily to a variety of subroles of the rehabilitation counselor. This subrole model, without specification of the role for the rehabilitation counselor, appears to be the core of the debates on rehabilitation counselor role and function (e.g., Anderson, 1958; Lambert, 1952; Patterson, 1957).

The rehabilitation counselor is caught in the middle of a role conflict situation in which the educators of rehabilitation counselors and other "experts" in the field prescribe one set of role dimensions while the actual job appears to demand another.

Overs (1964) noted that despite the efforts to professionalize vocational counseling, practitioners within the occupation may see this as undesirable. Within this profession, status comes from graduate degrees held. Those with advanced degrees are likely to get better jobs even though they may be no more effective than those without degrees. Downgrading within the occupation is accomplished by transferring the counselor to less desirable tasks, such as clerical work. In support of this, Patterson (1957) said that professional respect for the rehabilitation counselor can be developed only when the counselor serves as a counselor, using his unique skills in counseling rather than coordination.

Similarly, Whitten (1951) noted that the rehabilitation counselor is that professional person directly responsible for counseling handicapped persons; he may or may not have the additional responsibility for arranging the necessary services for a rehabilitation plan.

The complexity of the problem was discussed by Anderson (1958) in a rather blunt statement that the rehabilitation counselor should accept the reality that he cannot do counseling of the sort defined by the leaders in the field. The rehabilitation counselor must work within the limits of his specific role, seen by Anderson as that of a rehabilitation consultant.

Burdett (1960) stressed the importance of a rehabilitation counselor as a counselor, assisting the client with the psychological aspects of a disability, which may be more harmful than the physical aspects.

A Conceptualization of Counselor Role and Functions

The conceptualization of counseling that seems consonant with statements of the professional associations and the realities of service agencies is a role in which the counselor possesses a parallel responsibility both for counseling and for the provision of a continuity of services for the client. This concept is meant to connote a more subtle kind of behavioral science case responsibility. It does not apply to coordination in its connotations of administrative, non-counseling activities.

It is a role in which the counselor assumes responsibilities for monitoring the service process and serves as the client's advocate throughout the entire range of service programs.

Vocational rehabilitation service programs require a variety of services to be provided by a variety of professionals in a totally integrated plan of action. There are major problems such as surgical procedures, family and financial problems, physical therapy, speech therapy, psychiatric treatment, etc., to be dealt with by allied professionals. The ideal client possessing base potentialities that can be liberated solely by face to face verbal interchanges between client and counselor is rarely found in persons seeking services of rehabilitation agencies. The type of client with whom this so-called "counseling only" approach is most successful, infrequently seen by most counselors, presupposes a client who is verbal, self-insightful, and highly motivated to an increase of self-understanding.

The more typical rehabilitation client comes to the counselor because he is in need of assistance in overcoming major obstacles to employment. He needs medical services, psychological services, training, or change of career. Something stands in the way and thwarts his natural forward moving development. Thus, he turns to the rehabilitation agency as a resource that has considerable expertise and experience in problems of handicapping conditions, ways of increasing adaptation to the handicap, and facilitating natural human development.

Often the client, unable to profit from certain counseling approaches, has been classified as "unsuitable" or "unmotivated" for counseling or rehabilitation. (c.f. Thoreson, et al, 1968). This client is often the delinquent, from a multiproblem family, poor, of low intelligence, nonverbal, severely disturbed, possessing low-verbal skills or poor impulse control. Quite obviously, such a person is often one most in need of assistance from a professional counselor. Ideally what transpires between this client and counselor is a special human relationship, a caring relationship that is highly personal and subjective rather than objective and businesslike. The counselor manifests his concern both through face to face interpersonal

communication and through maintaining continuity in the rehabilitation process. The counselor serves as the client's advocate monitoring, clarifying, and communicating the client's choices to both the client and rehabilitation team. The counselor manifests genuine care and concern for his client in this process far more than is usually experienced in the casual day to day relationship. Such a climate is the sine qua non of the client's solution to his problem. It is a relationship in which the client is helped to gradually assume responsibility and, with it, control of his life. It is basic to the practice of counseling that it is the client's life not the counselor's and, thus, it is the client not the counselor who must assume ultimate responsibility and control. Admittedly, operationalizing this last point is difficult. The counselor, indeed, may know what is "objectively" best for his client. However, the client must add his owness to the personal equation. He must be final arbiter of what is best for him—not his counselor, physician, teacher, psychologist, or social worker.

Many professionals in social-service programs have espoused the belief that the problem of its clients may be effectively dealt with by an agency representative who has an inquiring mind, warm disposition, and knowledge of agency policies and community resources. From this it follows that a master's degree in counseling is not necessary. We would argue that while a master's degree provides no guarantee of competency, the behavioral science core in the master's degree program in counseling is a requisite to the function of the counselor as behavioral scientist. And to be of maximum benefit to the rehabilitation client it is necessary that the counselor be conversant with intrapsychic factors, interpersonal factors, sociocultural factors, and economic factors that affect his behavior. He becomes aware, thusly, of the ecological system of his client. These are the kinds of knowledge that are to be gained generally, but not exclusively, in graduate programs in counseling.

To help those in need of services but often reluctant to seek help from formal counseling programs, support personnel below the bachelors level are now being used. In many programs, personal contact, using trained workers from the client's own community in the homes, street corners, etc., has been found useful. Rehabilitation programs, employment service programs, O.E.O. programs, welfare programs, and secondary education programs have experimented in the use of support personnel in the delivery of services to their clients. This new group of personnel, variously referred to as auxiliary, ancillary, technical, nonprofessional, paraprofessional, or support personnel, is assuming non-counseling duties. These personnel are special assistants to help the professional counselor in special

situations and are not substitutes for the counselor. A statement of policy for such personnel ("Support Personnel for the Counselor: Their Technical and Non-Technical Roles and Preparation") was adopted by the American Personnel and Guidance Association (A.P.G.A., 1967).

It is also necessary for the counselor to have professional training to provide supportive intervention by a relationship that focuses upon trust and emotional support. Further it is necessary to prepare the counselor to help the client make decisions consonant with improved vocational adjustment. This is often a complex task involving a wide range of services and behavioral change strategies.

Finally, in order to be of maximum benefit to the client, it is necessary to build a base of professional identification that includes an awareness of the ethical standards, of responsibility for the welfare of clients, and of the need for continuous self analysis. Such analysis instills the value of intellectual endeavor and the willingness to examine the many complexly interacting factors that account for human behavior. Graduate training in counseling encourages the counselor to take an open and questioning attitude providing the basis for a partnership with clients and colleagues in the process of discovery. The counselor can serve as a model for the client while encouraging him to move out in his unique direction.

Graduate preparation in rehabilitation counseling must prepare the counselor to cope with changes that are unpredictable. In turn, the counselor can help his client adapt to his altered circumstances. As Heraclitus wisely said, "No man steps into the same river twice. The river flows and the man ages. All is change."

Professional Preparation and Practice: A Developmental Picture

In 1964, the American Personnel and Guidance Association adopted a statement of policy on "the counselor: professional preparation and role." This statement was concerned with the "common elements in the preparation and role of any specific group—to set forth broad policies and principles, which have general applicability throughout the A.P.G.A. membership, and to serve as a framework for more specific standards and criteria for each division." This statement was followed by the 1963 A.R.C.A. statement, the 1964 A.C.E.S. statement of policy, and the 1968 A.R.C.A. statement. These policy statements can be found in Loughary, et al., (1965) and A.R.C.A. (1968).

In August of 1968 the American Rehabilitation Counseling Association issued a statement of policy, the "Professional Preparation of Rehabilitation Counselors" (A.R.C.A., 1968). This statement recognized the special

preparation required by the rehabilitation counselor functioning as a professional in a rehabilitation setting. It applies only to the professionally educated counselor and not to other agency personnel. One of the authors of this chapter (Thoreson) served as chairman of the A.R.C.A. Committee that developed the statement. And it is felt that a review of the statement will help clarify counselor role and function.

The A.R.C.A. statement on counselor professional preparation and role acknowledges that though the functions of a counselor may vary from agency to agency, the role of the counselor is face-to-face communication with clients to bring about improved personal, educational, vocational, and social adjustment; and the ultimate objective remains a constant, viz., the welfare of the client and his eventual employment at an optimal level.

Prior to the formal issuance of this statement, a preliminary copy was submitted for comments to state agencies, private agencies, and university training programs in vocational rehabilitation counseling. Responses were received from a total of 85 persons, 46 of whom were from academic institutions, 39 from field agencies. Responses to the statement appear to reflect the major professional issues in counseling as perceived by scholars and practitioners in rehabilitation. They capture succinctly the essence of problems in counselor role and functions and are summarized below.

The division between academic and applied approaches was apparent. A considerable number of respondents, especially from the applied areas, questioned the reality of the professional standards. They noted the disparity between what the counselor is trained to do and that which he is asked to do in the consumer agency. Some wondered if high standards actually lead to the development of a "junior therapist" rather than a person that the field agency really needs. Others saw standards as an ideal yet felt that manpower needs in the field were so great that strict enforcement of the standards would only widen the gap between need and supply.

At least two implications for the standards may be read from these arguments: Disparities and paradoxes between training and practice are real and must be acknowledged. With strict training standards the result is a professional counselor who is a highly trained specialist. Yet many practical duties of the counselor could be handled by someone less intensively and extensively trained.

The critiques on the role and function of the rehabilitation counselor suggest that, while the statement is clearly written, the issues in the minds of educators and agency personnel are not clearly resolved. Some saw training standards as having a narrow goal of professionalization and at odds, in many instances, with the actual needs of clients, needs which they

felt were only barely touched upon by the standards. Others saw little differentiation of the role of the rehabilitation counselor from the role of psychologists or other kinds of counselors. Still others saw the field of rehabilitation today characterized by interdisciplinary cooperation, yet the unique contribution of the rehabilitation counselor and the way he works with others in rehabilitation were not, they felt, sufficiently clear in the statement.

It would appear that selective perception was operating when academicians read into the statement too great an emphasis on vocational placement while practitioners read into the statement too great an emphasis on counseling and psychotherapy.

The official statement, which was ultimately adopted by the American Rehabilitation Counseling Association and deemed consonant with the A.P.G.A. statement on the counselor, is: professional preparation and role incorporates the critiques of the wide variety of professionals in vocational rehabilitation who responded to the statement. These critiques indicate that a clear delineation of role and function of the rehabilitation counselor is not a simple matter to accomplish.

Yet while the functions of a counselor do vary in agencies according to the mandates under which a particular agency operates and the particular characteristics of the client population served, both educators and practitioners agree on the role of the rehabilitation counselor as professional counselor. Some stress the "counseling only" aspect of his role; others stress the "client advocate" aspect. The majority finally, however, recognize the unique contribution of the counselor as a behavioral science specialist who can provide a special caring relationship to his client. The crucial elements in the statement are herewith provided.

1. The standards apply to professional counselors who:

   "are employed in such public and private vocational rehabilitation agencies as State Division or Bureaus of Vocational Rehabilitation, agencies for the visually handicapped, rehabilitation centers, sheltered workshops, vocational guidance and rehabilitation centers, and rehabilitation units of mental health facilities. The counselor is a professional person and as such is expected to demonstrate expertness necessarily involving independent judgment in his areas of competence. He accepts and performs his work in consonance with a professional code of ethics as exemplified in the A.P.G.A. Code of Ethics. His proper expectation is that his work setting and work atmosphere will enable him to function as a professional person at a professional level. The professionally educated rehabilitation counselor will expect to receive technical supervision but this must come from those pro-

fessionally qualified through training and experience. The nature of rehabilitation counseling, finally, frequently requires professional relationships with others in counseling, related disciplines, and community agencies, in order to assure that the total needs of the clients are met."

2. Clients to whom counseling is provided are:
   "usually adolescents or adults who are handicapped either by physical, mental, social, or emotional disabilities which often have major socio-cultural and psychological ramifications and who, thereby, are usually in need of general counseling services as well as services specific to vocational placement. Though the focus is, typically, upon optimal vocational development and placement of the client, the concern of the agency and of the rehabilitation counselor is with the individual's total development and functioning as a contributing citizen in our society."

3. The objectives of Rehabilitation Counselor Preparation are to:
   "prepare the individual for entering upon a lifelong profession, not for a specific job or position. Education for a profession never ends. Therefore, the professional rehabilitation counseling curriculum is concerned with inculcating methods and patterns of learning, professional attitudes and identification, and a critical, questioning and exploratory attitude. Knowledge and skills are essential, but not sufficient. The ultimate objective of graduate preparation in rehabilitation counseling is to assure that clients of rehabilitation agencies receive high quality counseling services to which they are entitled."

4. The graduate curriculum has these assumptions:
   a) Rehabilitation clients have the right to receive counseling services from persons best qualified to do so. At present, the best assurance that a person is qualified to provide counseling services is graduate preparation in rehabilitation counseling. Experience, alone, does not give the same assurance.
   b) Adequate preparation in rehabilitation counseling requires two years of study, a substantial part of which is on a full-time basis.
   c) While the program may be adapted to different backgrounds and individual differences among students, there should be a well-defined and patterned sequence of courses fundamental to preparing the professional rehabilitation counselor.
   d) Paramount in this preparation is a development of an understanding of the philosophy and theory and the psychological, sociological, and economic principles that constitute the foundations of counseling. Techniques and skills are operating means of applying the principles built upon these foundations.

5. The curriculum includes the following elements, which are shared with all counselors:

The foundations of human behavior and dynamics of behavior change.

Social, cultural, and economic factors influencing individuals and groups, particularly in their economic and occupational aspects.

Professional studies in counseling:

a) Philosophic and assumptive bases of counseling.
b) Counseling theory and practice.
c) Group approaches to counseling.
d) Psychological appraisal by means of tests and other methods of evaluation and measurement, including the requisite statistics.
e) Occupational psychology, the psychology of vocational development, and the social environmental information necessary for vocational choices.

6. While there may be no specific courses dealing with the general, personal, and professional development of the rehabilitation counselor candidate, there should be opportunity, both formal and informal, for the candidat to:
   a) Develop in self-awareness and understanding, including opportunity for personal counseling.
   b) Understand, observe, or participate in research studies or activities.
   c) Engage in independent or advanced study in areas of special interest.
   d) Integrate the various aspects of the curriculum, including theory and practice.
   e) Identify and affiliate with appropriate professional organizations.

7. The curriculum includes the following elements that are specific to rehabilitation counselors:

Specific preparation for working with the kinds of clients to be encountered in the setting in which the rehabilitation counselor will work:

a) The nature of the settings, its agencies and their programs, and common problems.
b) The nature of the particular client population including any special characteristics, needs, and problems. This should stress study of the medical and psychosocial aspects of disability.

8. The curriculum includes supervised experience that provides a graduated series of experiences for the student.

In the earlier stages of the program, opportunities for observation (direct, or indirect as through films and tapes) should be provided. Laboratory experience in interviewing and testing should also be an integral aspect of the training prior to the assignment of complete responsibility for a client to a trainee. In addition, rotated, precounseling training assignments with rehabilitation agencies may provide trainees with relevant information about the structure and function of agencies and the nature of the client population.

9. Practicum experience in counseling should be provided. This experience should meet the following requirements:
   a) It should be meaningfully integrated with the didactic training. The experience should be intensive, concentrated, and under close supervision.
   b) This experience should consist of work with a number and variety of clients.
   c) Sixty hours appears to be an acceptable minimum for counseling relationships with clients. It is important that the student carry a number of clients for several contacts over a period of time.
   d) Close and direct (at least one hour per week) supervision should be provided including some first-hand observation of the student either through monitoring or through taped interviews. University supervisors should be counselors, preferably trained to the doctoral level, with experience in counseling beyond that acquired in practicum.
   e) Since growth in counseling requires time, the practicum should extend over a period of at least one quarter or semester program as a minimum.
   f) The practicum setting should be conducive to maintenance and progress of the counseling relationship.

10. The curriculum includes an internship. The internship is supervised experience in a rehabilitation work setting. It should meet the following requirements:
   a) The internship may be in a single rehabilitation agency or in more than one agency; it may be on a block or on a concurrent basis; it may be paid or unpaid experience. Regardless of the nature of the experience, it should be regarded as much more than observation or orientation. It thus must consist of concentrated periods of time in the agency setting so that the student gets the feel of the agency as a junior staff member and is able to carry cases over a period of time. Two full days a week appears to be the minimum time to achieve these goals. The experience should consist of a minimum of 480 hours of work in an agency setting.

b) The agency must provide adequate facilities, equipment, and materials for the student to function at a professional level.

c) The agency must provide day-by-day supervision by a supervisor, qualified by education and experience.

d) The educational institution maintains contact with the student and provides supervision, aimed at assisting the student to integrate his academic training with agency programs and requirements. University supervisors should have experience related to the agency in which the student is placed.

In summary, the role and functions of the counselor are bound by the dual realities of legislative mandate and agency policies, both of which should emerge from the realistic needs of clients.

While the counselor may often have a dual function of counseling and assuming responsibility for a continuity of multiple services, his role remains primarily that of professional counselor. For while the client may have multiple needs, the counselor can provide that special human relationship, highly personal and subjective, known as counseling; other client needs will have to be handled by others.

Graduate training provides the special skills and a solid background in the behavioral sciences for the counselor to function in day-to-day realities plus the flexibility to grow with the future from a solid base of professional identification and ethical responsibility.

The counselor functioning in the field may feel the conflict of academic, professional training with the practical demands of his job. A professional concept of role can give him the base for the realistic application of counselor functions in a service program.

ROLE AND FUNCTION OF COUNSELORS WITH DEAF PERSONS

Specialization in counseling the deaf person is a recent development. Organized attempts to recruit and provide professional training for counselors with deaf people have been made only in the last ten years. Because of this fact, efforts toward defining the specialists' role and function have been minimal. Up to the present time, there has been practically no research on the subject.

While a number of writers have strongly advocated the use of special counselors with the deaf (Craig, 1967; Falberg, 1969; Goetzinger, 1967; Levine, 1960; Lloyd, 1968, 1969; Ott, 1965, 1967; Patterson, 1965; Quigley, 1966; Stewart, 1967; Vernon, 1967; and Williams, 1967), there has been some disagreement as to what the role and functions of these counselors should be. In many ways, this controversy is similar to that

which took place in the general field of vocational rehabilitation during the 1950s.

Opinions regarding the role and functions of counselors with the deaf are varied. Some practitioners advocate the "coordinator model" in which the counselor provides a multitude of services. Cottle (1953), states that this type of counselor often views himself as a "combination parent, doctor, psychologist, teacher, policeman, public relations expert, personnel manager, and jack of all trades" (p. 446). Stewart (1967), on the other hand, views the specialist more in terms of the "counseling model." This model depicts the individual as a "professional counselor" whose main contribution to the rehabilitation process is his counseling function (McGowan and Porter, 1967).

The need to define the role and functions of the counselor with deaf persons has been stressed by Vernon (1967a). He cautioned that unless this is done there is a danger that universities will be "preparing counselors for a different world from that in which they and the client are going to function." However, the problem of defining the counselors' role and functions remains a most difficult task. Holbert (1965) and Patterson (1965) indicate that role definition and functions for the special counselor may be even more complex than that for the general counselor.

As noted in Chapter II, counselors with deaf people are employed in many different settings. For example, there are school counselors, therapists in mental hospitals, counselors working with parents of deaf children in speech and hearing centers, counselors in community service agencies, and counselors employed by state vocational rehabilitation agencies. The duties of these counselors may vary from working with mentally ill deaf people to providing genetic counseling to couples concerned about the possibility of hereditary deafness in children resulting from their marriage.

Since it is not possible in this paper to describe the wide variety of roles and functions that counselors with the deaf in differing settings assume, several examples may be taken as illustrative. The first of these will be counselors employed by state vocational rehabilitation agencies. This represents the largest single group of counselors with deaf people and is the only group on which we have research describing the counselors' role and functions.

Vocational Rehabilitation Counselors with Deaf Persons

At the present time, there are no accurate figures available on the number of rehabilitation counselors serving deaf clients. Williams (1967) has estimated, however, that there are only about one hundred counselors

who could be classified as having good to fair skills in serving deaf people.

Recent figures from the United States Department of Health, Education, and Welfare (1968) indicate that thirty-five state vocational rehabilitation agencies had recruited, or were actively recruiting, staff who could be classified as expert vocational rehabilitation workers for deaf persons. This is a significant increase over the sixteen state agencies that in 1948 provided special counselors for deaf and hard-of-hearing individuals (Hoag, 1948).

Despite the recent increase in the number of special counselors with deaf persons, Switzer (1966) estimated that fewer than 2,500 deaf people were rehabilitated each year when there may be as many as 50,000 deaf individuals in need or able to benefit from vocational rehabilitation services. To meet this critical manpower shortage, the National Citizen's Advisory Committee on Vocational Rehabilitation (1968) estimated that a total of 300 new counselors for deaf people will be needed by 1973.

It has only been within the last decade, more notably the last five years, that any systematic effort has been made to recruit and train professional counselors to work with deaf adolescents and adults. Beginning in 1958, the Rehabilitation Services Administration has supported a number of short-term training programs. According to Adler (1969), approximately 1,150 persons participated in short-term training courses in the areas of deafness during 1967. The Rehabilitation Services Administration has also supported a limited number of long-term training programs in deafness rehabilitation. In 1967, R.S.A. was supporting six such programs, and 45 traineeships were granted to persons interested in working with deaf people. Four of these programs were on the graduate level. The other two were nondegree programs providing an orientation to deafness for counselors and other professionals (Adler, 1969).

Until recently, vocational rehabilitation counselors with deaf people lacked any sense of professional identity. Generally, these counselors had little or no professional training in counseling and only rarely had contact with other specialists. Their performance was usually judged on the number of cases served, rather than on the quality of services provided. As a result, they found themselves spending more and more time on non-counseling functions and considerably less time on direct contact with deaf clients.

Within recent years, several changes have occurred that have helped to give the counselor with deaf persons a sense of professional identity. First, there is now considerably less pressure on them to close cases quickly. The 1967 amendments to the Vocational Rehabilitation Act authorized counselors to provide up to 18 months of extended evaluation

for deaf and other severely handicapped individuals. The 1967 amendments also permitted counselors to provide services to individuals who were considered to be working below their capacities and abilities (Rubino, 1967). Since underemployment is a common problem for deaf people, this change was welcomed by counselors working with them.

During the past several years, the Rehabilitation Services Administration has sponsored a number of workshops and conferences for counselors with deaf clients. These meetings have given counselors an opportunity to become acquainted with other professionals who share a common interest. This, in turn, led to the establishment of the Professional Rehabilitation Workers with the Adult Deaf, which provides counselors with a forum in which they can share common concerns.

The expansion of professional training opportunities has also helped to improve the counselors' self-image and sense of professional identity. Counselors with graduate degrees in vocational rehabilitation counseling with specialization in the area of deafness are gradually becoming more and more common in the field. Although much remains to be done before this specialty attains a true professional identity, a sound beginning has been made.

Quigley (1966) has described four types of vocational rehabilitation counselors who provide counseling services to deaf clients. First, there is the general counselor who, from time to time, has one or more deaf clients on his caseload. This is, by far, the largest group of counselors serving deaf clients. Second, there is the counselor who has a substantial caseload of deaf clients along with a "general" caseload. Deaf clients may represent 15 to 20 percent of this counselor's total caseload. Third, there is the rehabiltation counselor with the deaf (R.C.D.). This counselor may serve deaf clients throughout one state or in the more densely populated areas of a state. He may have his office in a school for the deaf or in a special facility. And finally, there is the state coordinator or consultant on rehabilitation of deaf persons. Several state vocational rehabilitation agencies have such positions. This type of specialist may consult with local agencies and counselors, conduct workshops, and perform other functions to improve rehabilitation services for deaf clients.

There is, at present, considerable variation among state vocational rehabilitation agencies in their staffing patterns and services for deaf clients. In a few of the more progressive states, a number of specialists are employed and the services offered to deaf clients are quite good. There are, however, a few states that still do not have even one counselor who can be called a specialist with the deaf.

Every state agency should have at least one person designated as coordinator of services for its deaf clients. This individual should possess an in-depth knowledge of rehabilitation and the unique needs of deaf persons. The state coordinator should have full authority and responsibility for developing an integrated state-wide program of services for deaf individuals. Counselors specializing in deafness should also be available in each of the metropolitan centers throughout the state. These counselors should be highly trained and able to communicate fluently with all types of deaf clients. There should also be a least one special counselor assigned to the state residential school for the deaf. In areas of the state where the number of deaf people is not large enough to warrant a full-time specialist, one counselor should be designated to handle all deaf clients. This counselor should have access to consultants when special problems arise.

A recent study (Tully, 1970) revealed that vocational rehabilitation counselors with deaf individuals perceive their role as one that combines both counseling and coordinating functions. In this study, the following four role models were operationally defined: (1) Model A—the counselor's role is primarily one of coordination of services, (2) Model B —the counselor's role is primarily one of counseling, (2) Model C—the counselor's role is one in which equal emphasis is placed on both coordination of services and counseling, and (4) Model D—the counselor's role is primarily one of consultation and administration.

Counselors were asked to select the model that most nearly described: (1) their present role, (2) the role that they would prefer if they were free to choose, (3) the role that they felt their agency would like them to assume, and (4) the role that they felt best qualified to assume.

Table 1 shows that two-thirds of the counselors described their present role as one that combined both counseling and coordinating functions. This was also the role that the majority of counselors preferred, felt best qualified to assume, and the one that they felt their agency preferred. It is interesting to note that only eight percent of the counselors described their

TABLE 1

Counselor Role

Role	Model A		Model B		Model C		Model D		Total	
	N	%	N	%	N	%	N	%	N	%
Present Role	26	20	10	8	84	66	7	6	126	100
Preferred Role	4	3	31	24	83	64	12	9	130	100
Agency Preferred Role	18	14	8	6	85	74	7	6	128	100
Role Best Qualified for	11	9	22	17	79	62	15	12	127	100

role as primarily one of counseling. This may be related to the fact that only 13 percent of the counselors surveyed held graduate degrees in rehabilitation counseling. In addition, only 28 percent of the counselors rated as good their ability to understand manual communication.

A comparison between the percentage of time that counselors with deaf clients devote to various functions and the percentage of time that they think they should devote to these functions was also made. In reviewing present functions, counseling and guidance was the largest single activity reported (27 percent). However, approximately the same amount of time (28 percent) was devoted to the combined categories of clerical work, recording, and reporting. This finding would seem to indicate that "paperwork" is a considerable problem for rehabilitation counselors with deaf clients.

The counselors felt that they should devote less time to clerical work, recording, reporting, travel, and other activities. By contrast, they felt that they should spend more time on counseling and guidance, overall planning of work, professional growth, public relations, program promotion, and placement.

Comparisons between counselor activity data from this study and three earlier investigations that dealt with general rehabilitation counselors were very similar. These data appear in Table 2.

The counselors in Tully's study (1970) reported that a number of factors tended to restrict them in their work with deaf clients. The most serious, in order of importance, were: (1) the small number and quality of psychological tests appropriate for deaf clients; (2) the limited number and generally low quality of training resources available; (3) the large amount of record-keeping required; (4) the long waiting period required for specialized medical examinations; (5) the ever present pressure for closures; (6) the restricting personnel policies of the agency; (7) the small number and quality of therapy resources; (8) the limited number of referral resources available; (9) the long waiting period for services from training resources; and (10) the limited amount of case service funds available and the regulations restricting their expenditure.

All of the counselors in this study devoted at least one quarter of their professional time to serving hearing-impaired clients. Eighty-seven percent had been employed in their present position less than five years and 34 percent had held that position less than one year. Generally, the counselors had only limited training in rehabilitation and the area of deafness.

Counselors in this study felt strongly that they should have smaller caseloads than other agency counselors. The shortage of resources available

TABLE 2

Comparison of Four Different Studies of Rehabiltation Counselor Estimates of Time Spent in Various Activities

Counselor Activity	1966[1]	IOWA 1964[2]	ARCA 1967[3]	RCD 1970[4]
Clerical Work	8.80	7.00	10.60	11.03
Counseling and Guidance	33.60	27.00	33.60	26.77
Overall Planning of Work	5.90	4.70	5.40	6.69
Professional Growth Activities	5.60	6.50	5.10	5.53
Public Relations and Program Promotion	8.00	6.80	5.70	6.02
Recording	10.60	18.50	10.60	11.17
Reporting	5.10	3.80	4.30	5.44
Resource Development	6.00	2.30	6.30	7.59
Travel	15.60	11.00	8.20	7.66
Placement		4.80	7.30	10.29
Other		7.80	3.00	2.19
Total	99.20	100.20	100.10	100.34

1. Office of Vocational Rehabilitation, Ninth-Annual Workshop on Guidance, Training and Placement (1966).
2. Miller, Muthard, and Barillas (1965).
3. Muthard and Solomone (1969).
4. Tully (1970).

in the community and the difficulties involved in serving deaf clients were the main reasons cited for having reduced caseloads.

Counselors with Deaf Individuals in Other Settings

As indicated previously, counselors with deaf persons are employed in a number of different settings. In some situations, the counselor's role is rather clearly defined while in other cases it is much more ambiguous.

At one end of the spectrum are counselors employed in community service agencies for deaf people. Generally, these programs are located in large metropolitan areas and are frequently attached to a larger agency. The services provided by these agencies are quite broad and may include everything from personal adjustment counseling to adult education.

Generally, the staff of the community service agency is quite small. As a result, the counselor may assume a number of subroles. In addition to providing counseling, he may also be responsible for administration of the agency. Other duties may include interpreting, teaching, psychological examinations, and consulting with other agency officials.

Deaf people who come to community service agencies generally have a number of different problems. Consequently, counselors often find them-

selves in the position of providing personal counseling and financial advice to the same client. This is a difficult situation at best.

Another problem faced by the community service agency counselor is related to the small size and close-knit characteristics of the deaf population. Generally, most deaf people using the services of an agency such as this usually will know each other. Some may be co-workers or members of the same family. This can often result in the deaf person being reluctant to divulge certain information to the counselor for fear that others will learn about it. To keep this from happening, special efforts must be made to maintain confidentiality.

While the conditions described above are less than desirable, they often are unavoidable. Without the necessary staff and other community resources, the counselor has little choice but to assume these additional responsibilities. The fact remains, however, that role conflict is a very real problem to these counselors.

In view of the conditions described above, it is rather surprising that the problem of role conflict for the counselor serving deaf persons has only recently been noted in the literature. Stewart (1967) called attention to this problem, especially as it relates to deaf professional counselors. He discusses the tendency among deaf counselors to select their social associates from outside the profession. Generally, these social contacts involve deaf individuals with whom the counselor works in a professional role. Stewart recommended that "while complete avoidance of such relationships is neither practical nor desirable, the deaf professional counselor should give serious consideration to avoidance of situations tending to compromise his effectiveness as a professional" (p. 25). Whitworth (1968) also noted this problem and cautioned that a deaf counselor may be too close to the world in which the client lives and, as a result, the client may be afraid that his personal problems will find their way back to his friends and peers.

Another type of counselor is the one employed in a special facility such as Gallaudet College or the National Technical Institute for the Deaf. Generally, these counselors are trained as counselors and are part of a professional staff which includes psychologists, social workers, audiologists, speech therapists, and job placement specialists. When problems arise that require the services of these other workers, the counselor need only make the proper referral.

As noted in Chapter II, counseling programs that exist in residential schools tend to be somewhat better than in public day schools and classes. However, in almost all school settings the role and functions of counselors are generally not clearly delineated.

For example, a number of counselors in educational programs have dual roles, i.e., they carry other duties in addition to counseling. In fact, in some schools counselors are also part-time teachers. This inevitably leads to role conflict and should be avoided whenever possible. Moreover, some school counselors attempt to provide guidance by lecturing in a classroom situation rather than on a one-to-one basis, as should be the case. The classroom approach may be suitable for the dissemination of occupational information, but individualized counseling is necessary for personal, educational, and vocational planning for the individual student.

Frequently, students and other school personnel have misconceptions regarding the role of the counselor. They may see him as primarily a guidance person. While guidance is an integral part of the counselor's work, it is by no means his only function. To remedy this, counselors should make special efforts to convey to others the goals of counseling as well as the role of the counselor.

In conclusion, it can be stated that the role and functions of the counselor with deaf persons are basically the same as would be the case were he working with hearing people. However, some exceptions to this generalization deserve note. First, the communication problems faced by the deaf client generally preclude referral to many of the resources the counselor of the hearing person would use. For example, a placement specialist unable to use sign language and uninformed about the vocational implications of deafness would not be able to work effectively with most deaf clients. Thus, the responsibility for placement would rest with the counselor. Other functions such as interpreting in interviews with physicians and lawyers, assisting in psychological testing, interceding with employers, and the like cause the role of the specialist with deaf people to be much broader and his counseling functions more varied than the counselor who devotes all of his efforts to counseling and delegates all other tasks to paraprofessionals or specialists in related areas. Thus, the counselor of deaf clients might be termed a "general practitioner" in the sense that his duties are quite varied. At the same time, however, he is a specialist with respect to his knowledge of the uniqueness of his client.

CHAPTER V

Counselor Selection, Education, and Training

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This chapter has two purposes. The first is to review recommendations published by divisional committees of the American Psychological Association, the American Personnel and Guidance Association, and the National Rehabilitation Association, dealing with the selection, education, and training of vocational rehabilitation counselors. Reports resulting from meetings of the Rehabilitation Services Administration sponsored annual workshops on guidance, training, and placement, reports prepared under the authority of the Joint Liaison Council, and the results of several appropriate Ph.D. studies are also reviewed for background data on training recommendations.

The second purpose of this chapter is to relate these recommendations to the selection, education, and training of counselors who are to work with deaf people.

Several parts of the chapter consist of revised and updated material that was originally prepared by McGowan and Porter for use in the R.S.A. training manual, *An Introduction to the Vocational Rehabilitation Process* (1967).

Material contained in earlier chapters of this book have helped to define vocational rehabilitation counseling and have identified the various roles and functions of counselors. These materials have established the fact that differences of opinion do exist in regard to the counselor's role and function that need to be examined in more detail before any definitive statements can be made in regard to training. This can best be accom-

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plished by reviewing the two different theoretical "models" of the counselor's role that dominate counselor training and practice at the present time and by considering present approaches used in preparing counselors for work with deaf people.

THEORETICAL MODELS OF THE COUNSELOR'S ROLE

As Chapter IV has indicated, the opinions expressed in the literature regarding the rehabilitation counselor's appropriate occupational role reveal two rather diffuse but nevertheless discernible theoretical models. The first model conceptualizes the rehabilitation counselor functioning as an interdisciplinary or sometimes multidisciplinary worker, a coordinator of services, and "captain of the rehabilitation team" (Coordinator Model). The other model depicts the counselor as being primarily a "professional counselor" whose main contribution to the rehabilitation process is his counseling function (Counselor Model).

Patterson (1957) discusses the rehabilitation counselor's role in an article entitled "Counselor or Coordinator?" He states that: "On this point there appears to be some difference of opinion, or confusion, or both" (p. 13). He further points out that the rehabilitation counselor training programs need an answer to this question in order to plan a course of study that will prepare counselors to perform their prescribed function. A discussion of the pros and cons of the Coordinator Model and the Counselor Model follows.

The "Coordinator" Model

Cottle (1953) has this to say about the rehabilitation counselor's job:

> In himself and his fellow counselors he (the rehabilitation counselor) sees a combination of parent, doctor, psychologist, teacher, policeman, public relations expert, personnel manager, placement specialist, and jack of all trades. Certainly the field of vocational rehabilitation is one of the broadest in the whole catalog of professions. (p. 446)

Hamilton (1950) and Johnson (1960) suggest that they do not perceive of "counseling" as being the counselor's major task. They try to show the counselor as a "coordinator" of many types of services, and therefore a person who must possess a multitude of skills based on a wide range of training. Johnston (1960) maintains that the rehabilitation counselor is not a psychologist, psychiatrist, sociologist, social worker, or physician. He is a "maverick" of the highest caliber drawn from all the above

and more. To quote him, "he is an expert coordinator of services . . . He has many general abilities and special abilities in at least two or more disciplines" (p. 9).

Fletcher (1954), sees the rehabilitation counselor as part of the team made up of medical, social service, hospital, placement, and other specialists. He feels that the rehabilitation counselor should be the team coordinator but does not see him as established in this role.

Hall and Warren (1956) and Smith (1960) list the following activities that are expected from rehabilitation counselors, although admitting that only an ideal counselor or person could perform all the suggested duties. According to them the counselor is asked to interview the client, evaluate his problems, help the client choose a rehabilitation plan, facilitate action on the plan, establish and maintain a counseling relationship, maintain relations with community organizations, interpret rehabilitation services to the public, encourage referrals, determine eligibility, collect and analyze educational and occupational data, administer psychological tests, assume responsibility for placement, and prepare case records and reports. In addition, the rehabilitation counselor is also expected to perform certain auxiliary services which include: Gathering material from employers and trade associations, assessing community resources, and making his own occupational and economic analysis.

Propst (1958) offers a three-part definition of the rehabilitation counselor's function:

1. A counselor is a member of the professional staff of an agency whose function is the rehabilitation of handicapped individuals.
2. He is an administrative agent to such individuals insofar as he supplies vocational information, arranges for tests, the purchase of prosthetic devices, interviews with others, workshop or training experience, and so forth, and insofar as he controls the client's utilization of, and passage through, the facilities he makes available.
3. He is a therapeutic agent to such individuals insofar as he provides a setting, and makes responses, of such character as to facilitate the client's working through, to some degree, that alteration in self-view of which, in part, his handicap consists. (p. 16)

Propst contends that the counseling and administrative roles of the rehabilitation counselor are compatible, and that, in fact such a combined function is both possible and desirable when working with a handicapped person.

The danger of holding to the "Coordinator" model is that the rehabilitation counselor *could* lose his perception of the client as a unique

individual. That is, there seems to be a danger that the "Coordinator" would become too *product-oriented* and begin to provide mechanically services without considering the personality dynamics involved in a client's problems. He then would be providing the services a client was entitled to by law without adequate consideration of the client's individuality or needs. Also, the training of "Coordinators" presents problems. To provide an individual with formal training in each of the areas listed in the Charlottesville report would take more time and money than is now available, and it is likely that a person trained this broadly would not be professionally competent in any area. The "Coordinator" might not have a professional identity, be neither fish nor fowl, and a "jack of all trades and master of none."

The "Counselor" Model

The proponents of the rehabilitation counselor as a "Counselor" criticize the above approach as being humanly impossible in terms of the counselor's ability and time for training, as well as making no new contribution to the rehabilitation process. Patterson (1958a) states the following in opposition to the "Coordinator" point of view:

> The rehabilitation counselor will become an accepted member of the team only if he can contribute as a specialist, not on the basis of having been exposed to a heterogeneous smattering of courses in these other fields. . . . The rehabilitation counselor is fundamentally a vocational counselor or a psychological counselor working with handicapped clients. He is not a member of a unique or interdisciplinary profession. Rehabilitation counseling will develop and advance as a profession to the extent that it recognizes itself as a part of the general counseling profession and identifies itself with other counseling specialties both in training and professional affiliation. (p. 312)

In another publication Patterson (1958b) offers the opinion that too often rehabilitation does things to and for the client rather than helping him learn to do things for himself. He stresses that there are several ways the counselor can help his client learn independence. They are: (1) counselor attitudes, (2) the softening of the "case-hardened" counselor to treat the client as an individual and not as just another case, (3) confidence in the client's ability to assume responsibility, (4) recognition of individual differences among clients, and (5) no counselor stereotypes of occupational choices (e.g., making shoe repairmen of lower-limb amputees, etc.). Patterson (1958b) feels that the rehabilitation counselor can only gain personal independence and professional status through his identification with the area of counseling.

Garrett (1953), Miller, Garrett and Stewart (1955), Lofquist (1959), and Anderson (1958) also perceive the rehabilitation counselor as a person professionally trained as a counselor. They recognize that the rehabilitation counselor's role often includes other functions that cannot be described as counseling. However, they feel that the basic identification of the rehabilitation counselor should be with counseling.

In discussing the rehabilitation counselor as a counselor, Anderson (1958) points out problems in defining the rehabilitation counselor's role. He says that the "actual" (coordination role) and "ideal" (counseling role) are widely separated, but that this state of affairs is maintained by the necessity of reality. He proposed that the quandry could be resolved by: ". . . the counselor's ability to create a warm, understanding relationship with his clients which does not necessarily have as its purpose 'counseling.' For want of a better term this can be labeled as a *therapeutic climate*" (p. 5).

There is an inherent danger in the "Counselor Model." This danger is that in terms of actual practice the rehabilitation counselor who, through a combination of training and personal preference, perceives his job as primarily involving counseling, *may* become more therapeutically ambitious than either the local agency or the average client is willing to "buy." However, in spite of this danger the rehabilitation counselor needs to be trained as a professional counselor and to possess the knowledge related to this profession in order to provide comprehensive and adequate rehabilitation services based on a philosophy of counseling and individual needs.

Role Conflict

Evidence that there is no clear agreement on the rehabilitation counselor's occupational role may be found in Smith's (1960) unpublished doctoral dissertation completed at the University of Missouri. He designed a study to identify areas of agreement and disagreement concerning the counselor's role by sampling the opinions of three groups of rehabilitation personnel: (1) state agency counselors (N=160), (2) directors and supervisors of state agencies (N=44), and (3) students in graduate training in rehabilitation counseling (N=61). Opinions regarding eight counselor duties were sampled. These were: (1) counseling, (2) testing, (3) office routine, (4) placement, (5) incidental services, (6) occupational information, (7) public relations, and (8) counselor self-improvement. He found significant differences of opinion concerning the counselor's occupational role within or among the groups of rehabilitation personnel on all the duties except counselor self-improvement. The differences found were

apparent among rehabilitation counselors, their supervisors, and rehabilitation counselor trainees, as well as among counselors from different states and different training institutions. Smith (1960) concluded that the differences in opinion on the counselor's role might lead to difficulties in communication and role perception between these groups. Therefore, continued attempts to reach a mutually acceptable definition of the rehabilitation counselor's occupational role would seem essential.

A dissertation by Johnson (1961), also completed at the University of Missouri, reports differences between how rehabilitation counselors and their clients perceive the counselor's role. The investigator devised four scales, each representing one major component of the rehabilitation counselor's role. These were: (1) The counselor as a "Counselor," (2) the counselor as a "Coordinator," (3) the counselor in terms of his "socio-economic and academic status," and (4) the counselor in terms of his "personality, mannerisms, cleanliness, and dress." Johnson (1961) drew the following implications from his study:

> Role conflicts exist in rehabilitation counseling as indicated by significant differences in all of the scales.
>
> Clients prefer rehabilitation counselors who "fit" the clients' established concept of a "good" personality. Perhaps fewer role conflicts would develop, in rehabilitation counseling, if rehabilitation counselors had an even greater understanding of personality development and interaction than they now have.
>
> Better communication is needed between rehabilitation counselors and their clients. The clients do not know what to expect from the counselor, or how to react to him. The clients have a vague idea of the services rehabilitation counselors are expected to deliver or to perform, but many services expected by the client are not the same services which the counselors are prepared to deliver.

Patterson (1957), offers four possible solutions to the conflict regarding the rehabilitation counselor's occupational role. His solutions are as follows:

> One would be to consider the counselor as primarily a coordinator, and develop a training program which includes a sampling—a smattering—of knowledge from a broad area, including legal aspects of public assistance and social welfare programs, detailed medical information, administration of social welfare benefits and programs, public relations information, and social casework procedures, as well as some limited acquaintance with counseling. This seems to be the emphasis of a few of the recently developed training programs in rehabilitation counseling.

A second approach would be to try to train an individual for both functions, for counseling and coordinating. Some training programs appear to be struggling to do this, which appears to be impossible in the time available.

A third alternative is to concentrate on the training of competent counselors in the time available. This is the approach taken by many employers of rehabilitation counselors, who seem to desire coordinators rather than counselors.

Before suggesting a fourth alternative, I should like to indicate the advantage of this third approach. In the first place, an individual who is well trained as a counselor is trained in a basic profession which extends beyond the field of rehabilitation. While there are those, some of them quite vociferous, who would make of rehabilitation counseling—or coordinating—a new and distinct profession, that is, in the opinion of the writer, a shortsighted view of the goal. Counseling is broader than rehabilitation, and its basic principles are the same whether one is counseling children, adolescents, high school students, delinquents, college freshmen, displaced persons, those with marital problems, the emotionally disturbed, or the physically handicapped. To be sure, a counselor specializing in any one of these areas needs training—or experience—in working with the particular type of client. But this, although necessary, is not sufficient, or even primary. The individual with good basic training in general counseling principles and methods can quickly learn to work with a particular type of client.

The individual with good basic training as a counselor is then versatile with respect to the type of clients with whom he can work. This may be seen as a disadvantage by some who fear that the field of rehabilitation will lose its counselors to other fields if they are so well trained as to be in demand in many fields. Here, no doubt, is a real danger. But if it is to attract and keep competent counselors, rehabilitation must compete with other fields. It is precisely this inability to compete in terms of salary and congenial working conditions, including the opportunity to do professional counseling, that is responsible in part for the present lack of staff and applicants. But the recognition of the important role of counseling in the rehabilitation process, and the developing of the counseling phase, with the opportunity for well-trained counselors to contribute at the level at which they are trained, rather than demanding that they be jacks of all trades and masters of none, will lead to the development of professional respect for rehabilitation counselors. That this is possible has been demonstrated by the Veterans Administration programs.

Another advantage of this approach is that counselors with such training can act as coordinators. Without belittling the requirements of a good coordinator, it can be stated that a well-trained counselor can function better as a coordinator than a coordinator can function as a counselor. Much of the background and training for functioning as a

coordinator is better achieved through experience than through formal training. The coordinator need not necessarily be a counselor, of course. In some situations the social worker may best function as the coordinator, and in other situations other specialists may perform this function.

While a counselor may function as a coordinator, however, it would be harmful if he were to perform such a function to the extent that he was unable to do an adequate counseling job with his cases, which is a situation existing all too frequently today. If he is to function entirely as a coordinator, then other counselors should be available to perform the counseling function. It would also be unfortunate if the coordinator's position were considered to be a higher level or more valuable function than that of the counselor. If this became the case, with coordinators having higher status and salaries than counselors, the counseling function would suffer because of inability to attract competent and well-trained counselors to the field.

A fourth alternative was mentioned above. Perhaps, instead of thinking in terms of either counselors or coordinators, we should be thinking in terms of counselors and coordinators. It may be that there are two distinct functions and two positions, so that in many situations, we should have both.

McGowan (1960) has previously stated that the rehabilitation counselor's job includes, "the ability to establish and maintain a wholesome counseling relationship, including an understanding of the importance of the client's views and needs. . . ." (p. 40).

While this statement emphasizes the rehabilitation counselor as a "counselor," it goes on to indicate cognizance of other aspects of the counselor's job. The rehabilitation counselor needs the professional training of a counselor in order to have a knowledge and awareness of personality dynamics and evaluative techniques. *In addition* to these skills he must also know community organization, job structures and requirements, and the legal and clerical factors associated with his job. Before the rehabilitation counselor can recognize the needs of his clients and adequately "coordinate" the indicated services, he needs to have all the skills associated with a professional counselor.

The Counselor's Actual Role

An important consideration of the rehabilitation counselor's occupational role is how he actually spends his time on the job. Of course, this will vary between and within agencies, depending on the nature of the counselor's caseload, the size of his territory, administrative policy, and the counselor's own interests and abilities.

Miller, et al (1955), in formulating a job description for the rehabilitation counselor, list the following as examples of the work performed:

> Obtains, analyzes, and evaluates pertinent information: arranges for medical diagnosis to determine kind and extent of disability and rehabilitation possibilities; and determines eligibilty on the basis of law and established policy.
>
> Secures information about the applicant's educational background and work experience, special interests, social and economic circumstances, personality traits and attitudes; provides for the administration and interpretation of psychological tests, when indicated for diagnosis; evaluates and interprets information and assists the individual in making a suitable rehabilitation plan.
>
> Makes rehabilitation services available to the applicant, such as *medical and health services* necessary for physical restoration, prevocational and vocational training, transportation and maintenance when required; advises with the applicant throughout the rehabilitation process and assists him in meeting problems of personal, social, and vocational adjustment.
>
> Aids the individual in securing employment consistent with his capacities and preparation, and assists him in meeting the problems of adjustment; makes followup visits as necessary for vocational adjustment of the individual.
>
> Makes use of available community services and facilities and maintains working relationship with cooperating agencies; when gaps exist in services, makes necessary recommendations.
>
> Gathers information on occupational requirements and keeps informed on employment possibilities. Prepares and maintains necessary vocational rehabilitation records and makes reports as required. (p. 444)

A Committee on the Utilization of Counselor's Services of the Ninth Annual Workshop on Guidance, Training and Placement (1956) conducted a study of counselor activities. An inspection of the findings can provide an indication of how counselors utilize their time and some idea of the various types of activities that rehabilitation counseling involves.

The committee gathered information from the top one-third of the regular counselors from several States. The counselors were selected for having achieved both quantity and quality in production. Each participant was sent a questionnaire requesting an analysis of his time spent in the following 10 areas: (1) clerical work, (2) counseling and guidance, (3) overall planning of work, (4) professional growth, e.g. in-service training, (5) public relations and program promotion, (6) recording, (7) reporting,

(8) resource development, (9)travel, and (10) social security disability determination.

The 139 counselors who participated in the study report the following distribution of their time (in hours) over a 40-hour week:

Activity	Average No. of hours	Range of hours
1. Clerical	3.53	0 -13.3
2. Counseling and guidance	13.44	2.8-24.3
3. Overall planning	2.35	0 - 7.2
4. Professional growth	2.24	0 - 7.8
5. Public relations	3.19	0 -10.5
6. Recording	4.23	.3-15.5
7. Reporting	2.04	0 - 8.3
8. Resource development	2.39	0 -10.0
9. Travel	6.24	1.5-12.0
10. S.S. disability determination	.31	0 - 3.9
Total	40	——

In a second part of this study, the counselors reported that they would like to be able to spend more time in counseling and guidance and public relations. Also, they felt that too much of their time was consumed by clerical work and duties that could be delegated to nonprofessional personnel.

A part of Peterson's (1964) study of "Counseling in the Rehabilitation Process" was designed to determine how state agency counselors utilize their time in providing rehabilitation services to their clientele. From a sample of 26 counselors and 213 of their clients he reported the following analysis of how the counselors spent their time providing rehabilitation service to clients:

Activity Area	Percent of clients who were recipients of the activity	Percent of counseling time spent in the activity
Administrative functions	99.5	26.5
Discussion with clients (counseling included)	97.7	54.1
Arranging services	67.1	10.9
Obtaining information	7.5	.7
Consulting with others	13.2	4.1
Case record review	5.6	1.6
Testing	11.7	2.1

The results of these studies clearly suggest that a marked discrepancy exists between what a counselor actually does in a typical vocational rehabilitation agency and how he is trained to function while in many graduate schools.

McGowan (1967) submits the following personal observations on the rehabilitation counselor's unique role:

> For me, personally, the vocational rehabilitation counselor's unique contribution to handicapped clients consists of his intrinsic interest, special training, and supervised experience, which have prepared him to combine medical data from the physician, psychological data from the psychologist, psycho-social-vocational data based on his own special training in testing and counseling, and information about the world of work obtained from the employment service and other sources, and to transmit these combined data through the counseling process to the client in such a way that together they are able to arrive at a vocational plan which is acceptable to both the client and the counselor, and which promises the client the best possible chance of achieving job satisfacton and vocational success.

By way of summary, role conflict does exist in regard to the rehabilitation counselor's role. The review of A.P.A., A.P.G.A., and N.R.A. training recommendations which follows does not identify or emphasize these differences. Nevertheless, limited research data by Peterson, Johnson, and Smith, plus personal observation, could support the fact that such conflicts do exist both in counselor training and practice.

Counselor Education and Training

General Recommendations. The American Personnel and Guidance Association (A.P.G.A.) in a report edited by Loughary, Stripling, and Fitzgerald (1965) lists a set of professional principles that, combined with certain curricular recommendations, form the core of professional education and training for all counselors.

The professional principles condensed and reformulated for use here are stated in the paragraph below.

Counselor education should have specific goals and should be based on philosophic values that reflect high professional and social standards. The curriculum should be flexible and reevaluated intermittently in order to allow for necessary alterations. The curriculum should provide essential educational content and experiences and emphasize candidate individuality, growth, and self-understanding. The program should assure the adequate background and preparation of the candidate and provide specialized study relating to the setting in which he will ultimately work. There

should be an integration of studies from various disciplines as these are relevant to the course of study. The program should be a minimum of two years in duration and should encourage full-time study (pp. 79-80).

The report makes the following general recommendations in regard to counselor preparation.

1. Professional study in counseling should provide counselors with a knowledge of counseling theory and practice; group procedures; testing and other methods of psychological and educational appraisal; the cognitive and emotional process of growth, change and adjustment; the social, educational, and work environment; economic, psychological and sociological aspects of work and vocational development; statistics; research methodology; legal responsibilities and professional ethics.
2. Essential in the core of counselor preparation is supervised experience such as laboratory work, counseling practicum, and internship. Criteria for practicum and internship settings should include quality of professional supervision and of learning opportunities plus their applicability and adequacy for the employment setting in which the counselor candidate expects to work. The candidate should work with a variety of counselees appropriate to his eventual employment under conditions that protect the interests of the counselee as well as contribute to the competence of the counselor candidate.
3. Counselor preparation should emphasize philosophy, theory, and scientific knowledge as well as specific techniques and procedures in a manner that assures understanding and mastery of counselor functions and that helps the counselor candidate to learn to adapt his professional self-concept and his professional skills to a variety of work situations. Learning experiences should encourage creative thinking and inquiry; the ability to use research and evaluation as a professional tool; and a recognition of the need for continued professional growth. (p. 81)

The Division of Counseling Psychology of the American Psychological Association has also published recommendations concerning the training of counselors (Thompson and Super, 1964). While these recommendations are intended for graduate programs at the master's and doctoral levels, they do not differ in principle from those of A.P.G.A. The report specifies that training should include a core of basic concepts, procedures, and tools that are commonly used by all psychologists. It proposes course work in the following areas.

1. *Personality Organization and Development.* This area deals with personality and social theory, theoretical and philosophical aspects of counseling and psychotherapy, developmental and

abnormal psychology, social and cultural factors of personality, and language patterns involved in personality development.

2. *Knowledge of Social Environment.* The individual should be familiar with cultural and social structure and the problems which arise in that context. It is also important that he be familiar with community resources and their utilization.
3. *Appraisal of the Individual.* The counseling psychologist should be skilled in the use of a variety of pertinent tests and have the ability to make accurate diagnostic decisions. Courses in testing, test theory, and various evaluative techniques are essential.
4. *Counseling.* Course work in this area should cover theories of counseling and psychotherapy, different techniques and trends in individual and group counseling and aspects of mental hygiene.
5. *Professional Orientation.* The student should be trained concerning the numerous facets of professionalism and professionalization. This should involve courses in ethics and professional problems, and should impart an understanding of the responsibilities of differing roles and positions within various organization structures.
6. *Practicum.* The purpose of practicum is to develop the counselor's abilities in actual counseling relationships, to allow him to apply academic information to realistic problems, to permit him to attempt different modes of functioning and consequently, evaluate his performances with the assistance of an understanding and experienced supervisor. Practicum also provides time for discussion and comparison of various techniques and issues with supervisors and peers which contributes to the intended goal of congruent and competent counselor functioning.
7. *Research.* Training for research should include appropriate course work in addition to providing opportunities to learn necessary techniques through actual research participation. Students vary in their interest and abilities in this area and an adequate balance between practice and research may be obtained by taking the student's potentialities into account. (pp. 116-19)

The Training of the Rehabilitation Counselor

The realization of a need for trained rehabilitation counselors to work with the handicapped is reflected in the Vocational Rehabilitation Act of 1954 (Public Law 83-565). This act authorized the Vocational Rehabilitation Administration to encourage and support the development of counselor training programs in universities to provide for the graduate training of rehabilitation counselors. By 1957, more than 30 universities had developed graduate programs in rehabilitation counseling, and in 1966, 41 programs were in actual operation while 16 more were in various stages of

curriculum planning and recruitment of students. In 1966, of the total $24,800,000 appropriation for training rehabilitation personnel, the share accorded to the training of rehabilitation counselors was exceeded only by the share given to rehabilitation physicians.

There are wide variations in viewpoints among professional rehabilitation workers as to just what should constitute desirable knowledge and skills for the counselor. Whitten (1954), observed that when Public Law 83-565 was passed there were no generally acknowledged criteria for evaluating the qualifications for a rehabilitation counselor. This was not true of other disciplines engaged in rehabilitation. Unlike the rehabilitation counselor, most other professional workers in rehabilitation had approved schools, established curriculums, and general standards by which a determination of qualifications of a person to perform the functions of the profession he represented could be made.

As pointed out earlier, there are disagreements regarding whether the counselor should be trained primarily as a "counselor" or a "coordinator." The opinions expressed in the literature regarding the proper training for rehabilitation counselors exemplify this dichotomy.

McDonald (1944), made a thorough study of the state-federal legislative program in rehabilitation through the 1943 amendments to the Vocational Rehabilitation Act. As a part of her study, she analyzed the personnel standards and qualifications for those employed in the program. She found that the tendency had been to select personnel from the field of education rather than from areas that focus on the adjustment problems of the individual. It was McDonald's opinion that the work of vocational rehabilitation is primarily a complex application of social casework. She feels that a person could not prepare in all the specialities demanded in this work and that the basic preparation should be in casework, with consultants filling in the other specialized areas.

Hahn (1954) suggests that the counselor's training should be divided into four areas: (1) psychological training, 40 to 50 percent of the curriculum, (2) social casework, 30 to 40 percent, (3) medicine, 10 percent, and (4) contributing areas, 5 to 10 percent.

Patterson (1957), feels that the training time of rehabilitation counselor trainees would be more profitably used by concentrating in the psychological area in order to make them better counselors, rather than half-trained social workers.

In the years following the passage of Public Law 83-565, considerable effort has been made toward clarifying the problem of suitable criteria for evaluating the job of rehabilitation counselors: nevertheless, we still

see a general lack of agreement among persons in rehabilitation regarding the precise ingredients of desirable training, and, as a consequence, confusion in regard to the particular profession with which rehabilitation counseling is to form primary identification. However, there are data available that tend to indicate some positive movement and suggest significant long-term trends.

One indication of the course that the training of rehabilitation counselors is going to take may be found in the professional identification of the coordinators of the university rehabilitation counselor training programs. A report by the American Psychological Association's Division of Counseling Psychology (1963), entitled "The Role of Psychology in Preparation of Rehabilitation Counselors" indicates that 85 percent of directors of the rehabilitation counselor training programs received their graduate training in an area of psychology. Nearly 90 percent of these directors hold doctorates.

The professional identification of the directors is reflected in their professional affiliations. The chart below shows the percentage of the directors (N=31) who are members of the National Rehabilitation Association (N.R.A.), American Psychological Association (A.P.A.), American Personnel and Guidance Association (A.P.G.A.), and of divisions within these organizations:

The Professional Affiliations of the Directors of Rehabilitation Counselor Training Programs

Organization	Percent of directors that are members (N=31)
1. N.R.A.	90
2. A.P.A.	74
a) Division 17—Counseling Psychology	55
b) Division 22—Psychological Aspects of Disability	64.5
c) Other A.P.A. divisions	25
3. A.P.G.A.	94
a) American Rehabiltation Counselor Association	90
b) National Vocational Guidance Association	49
c) Other A.P.G.A. division	22

Therefore, by the training and professional identification of the directors of the counselor training programs it appears that the training programs are emphasizing a psychological and/or counselor-oriented curriculum. In fact, this same report indicates that *all* of the counselor training

programs have curriculums that consist of between 40- and 100-percent psychology courses.

A.P.A.'s Division of Counseling Psychology

In December 1963, a special committee published a mimeographed report entitled "The Role of Psychology in the Preparation of Rehabilitation Counselors." Committee members were: John Muthard, Chairman; Vivian H. Hewer; Abraham Jacobs; John F. Kinnone; and Cecil H. Patterson. Exerpts from the report follow:

Some Underlying Principles

A. Rehabilitation, to meet its goal, must deal with the total personality.

B. Basic counseling philosophy and techniques are essential dimensions of rehabilitation. These include the necessity for relating a career choice to an individual's basic interests, personality, and capabilities, and the techniques of appraisal, interviewing, and counseling.

C. The psychological content of the rehabilitation counselor preparation program should be the core part of the total program. At least fifty percent of the program should consist of preparation which is psychological in nature. At present, practically all programs better this standard.

D. The preparation of rehabilitation counselors, though psychological in nature, need not necessarily be conducted by a department of psychology, but may be locked in a college or school of education and conducted by a department of educational psychology. Courses offered by departments of psychology may be integrated with psychological courses offered by the school or college of education. In any event, psychology courses should be taught by qualified psychologists.

E. The nature of the graduate preparation in psychology will depend upon the previous work of the student, including his undergraduate preparation. Since an undergraduate major in psychology is not required, and perhaps is not even desirable, students will have varying backgrounds and preparation in psychology. Placement or proficiency examinations should be used as a basis for planning the work of the individual student.

F. In view of the amount and variety of preparation required for effective functioning as a rehabilitation counselor, two academic years are normally necessary to achieve basic competency.

G. Because of the sequential nature of much of the preparation, and the need to integrate work from several areas, sometimes

by parallel sequences, full-time study is desirable for the preparation of rehabilitation counselors.

The Content of Preparation in Psychology. Rehabilitation counseling, like all fields of counseling, finds its basic tenets and rationale in the discipline of psychology. As in the training for any profession, it is important that the student of vocational rehabilitation be given a thorough background in the basic scientific principles which form the base of his practice and that he not rely on practice of a restricted set of skills. Such scientific training provides the background for new insights, flexibility, and resourcefulness in practice. Thus, the training of vocational counselors should include courses in the theoretical and empirical aspects of psychology as well as courses concerned with the practice of the profession.

A. *Basic.* Basic preparation in psychology should consist of upper level undergraduate and graduate courses, based upon the introductory course in general psychology and educational psychology. Areas of study should include:
   1. Developmental Psychology
      a) The concept and principles of development
      b) The nature of development during the life span
      c) The nature and extent of individual differences in development and at various stages of development
   2. Personality
      a) Survey of theories of personality
      b) Mental hygiene and abnormalities of behavior
   3. Learning and Behavior Change
      a) Processes of behavior modification
      b) Theories and principles of learning and motivation
   4. Social Psychology
      a) The structures and behavior of groups
      b) The effects of group membership on an individual's attitudes and behavior
      c) Social class structure, occupational mobility, and its effect on the individual's attitudes and behavior

B. *Professional.* In the teaching of this area, the content should be related to the basic scientific materials from which it derives.
   1. Vocational Psychology
      a) Relationship between demands of the occupation and the characteristics of the individual
      b) Occupational and educational information
      c) Vocational development, vocational choice, and vocational adjustment
   2. Psychological Appraisal
      a) Principles of measurement
      b) Study of techniques, including standardized tests, ques-

tionnaires, and interviews with emphasis on their validity, development, and appropriateness for:
1) Assessment of intellectual level, special aptitudes, and achievements
2) Evaluation of vocational interests
3) Assessment of personal adjustment
4) Biographical assessment

c) Integration of data

3. Psychology of Counseling
   a) Theories of counseling and their relationship to theories of personality
   b) Study of techniques and methods used in the counseling interview with some emphasis on relationship of techniques to counseling theory
   c) Relationship of counseling techniques to goals of client; educational and vocational decision-making, and personal and social adjustment
   d) Group procedures
   e) Evaluation of outcome of counseling
   f) Professional relationships and ethics
4. Psychology of Disability
   a) Psychological aspects of disability
   b) Social psychology of disabilities
   c) Interrelationships of physical and social aspects—somatopsychology
5. Supervised Practice in Counseling
   a) Laboratory experience
   b) Practicum experience (one semester minimum)
   c) Field or internship experience (500 hours minimum)

C. *Interdisciplinary (including psychology)*
1. Statistics: application to psychological problems
2. Medical information: essential to an understanding of the vocational rehabilitation of an individual with physical and emotional disabilities
3. Social agency structure and functions

A.P.G.A.'s American Rehabilitation Counseling Association

This statement, by the American Rehabilitation Counseling Association is one of a series of statements prepared to supplement the A.P.G.A. Statement of Policy on *The Counselor: Professional Preparation and Role.* The A.P.G.A. statement is concerned with the common elements of counseling required for high-quality performance in any setting in which professional counselors function. The present statement enlarges upon the A.P.G.A. statement to delineate the special preparation required by the

professional rehabilitation counselor who functions in a rehabilitation setting.

These standards are concerned with the preparation of professional counselors who are employed in such public and private vocational rehabilitation agencies as state division or bureaus of vocational rehabilitation, agencies for the visually handicapped, rehabilitation centers, sheltered workshops, vocational guidance and rehabilitation centers, and rehabilitation units of mental health facilities.

As the A.P.G.A. Policy Statement emphasizes, the counselor is a professional person and as such is expected to demonstrate expertness necessarily involving independent judgment in his areas of competence. He accepts and performs his work in consonance with a professional code of ethics as exemplified in the A.P.G.A. Code of Ethics. His proper expectation is that his work setting and work atmosphere will enable him to function as a professional person at a professional level. The professionally educated rehabilitation counselor will expect to receive technical supervision but this must come from those professionally qualified through training and experience. The nature of rehabilitation counseling, finally, frequently requires professional relationships with others in counseling, related disciplines, and community agencies in order to assure that the total needs of the clients are met.

This statement takes cognizance of current shortages of professionally qualified rehabilitation counselors. The guidelines offered in this statement apply solely to the functions and responsibilities of the professionally educated counselor and are to be distinguished from guidelines for related agency personnel who may be employed to carry out some of the noncounseling services required by clients of rehabilitation agencies.

Level and Nature of Curriculum. An adequate curriculum of rehabilitation counselor preparation should meet the following requirements:

1. Rehabilitation clients have the right to receive counseling services from persons best qualified to do so. At present, the best assurance that a person is qualified to provide counseling services is graduate preparation in rehabilitation counseling. Experience, alone, does not give the same assurance.

2. Paramount in this preparation is a development of an understanding of the philosophy and theory, and the psychological, sociological, and economic principles that constitute the foundations of counseling. Techniques and skills are operating means of applying the principles built upon these foundations.

3. Adequate preparation in rehabilitation counseling requires two years of study, a substantial part of which is on a full-time basis.

4. While the program may be adapted to different backgrounds and individual differences among students, there should be a well-defined and patterned sequence of courses fundamental to preparing the professional rehabilitation counselor.

The curriculum should include the elements that are described in Chapter IV, pages 95–99.

N.R.A.'s National Rehabilitation Counseling Association

The Association has not published a committee report on counselor preparation; however, in a discussion of "The Rehabilitation Counselor—What He Is and Does," *R.C.D. Professional Bulletin* (Reger 1963) states:

> Effective rehabilitation requires individualized, comprehensive, and integrated professional services. Rendering such services for an individual requires skillful rehabilitation counseling in the evaluation of clients needs, the definition of goals, and the implementation and integration of all professional and other services into a total plan for the achievement of these goals. In order to implement a total plan for rehabilitation, any rehabilitation counselor who accepts the responsibility for counseling the handicapped must be the essential tie between the individual and various other professions and agencies that render services to the handicapped person.
>
> The knowledge, abilities, and skills needed by the rehabilitation counselor in order to be of optimum service to handicapped individuals require a high level of professional training and well-supervised experience.

Rehabilitation counselors perform in any setting in which they may assist disabled clients in moving to goals of self-realization and a productive life. Specific functions and practices of the rehabilitation counselor may vary, depending upon the setting in which he works. In general, the following reflect "The Rehabilitation Counselor—What He Is and Does":

A. Who is he?
   1. He is a person capable of, and continuously applying himself to, studying and gaining understanding of behaviors of individuals and society as they interact from the impact of disability.
   2. He is a person capable of practicing skills that use the client-rehabilitation counselor relationship to help the client develop and realize suitable goals.

3. He is a person whose proficiency will demand his knowledge and skills in the areas of economics, business administration, labor market information, job analysis (from the view of physical, mental, and emotional requirements), labor-management relations, legal and regulatory requirements for employment, and vocational counseling—in addition to medical information and community organization.
4. He is a person whose knowledge, in addition to that of behavior dynamics, must include knowledge in *depth* of the world of work, and his skills in applying it to meet the needs of the disabled must be so effective that he can claim this sphere of function as his and that of no other professional.

B. How does he function in practice?
   1. With the disabled client (rehabilitation counseling and casework), the rehabilitation counselor—
      a) communicates with the client to assist him directly in achieving optimum self-realization;
      b) shares knowledge of resources that can help the disabled person meet his needs in movement to self-realization;
      c) helps the disabled person determine his assets and limitations in his path to self-realization; and
      d) plans use of services and resources and assists in implementing such plans.
   2. With others, the rehabilitation counselor—
      a) works with other professionals in helping the client move toward maximum adjustment;
      b) develops and sustains a community climate to support the disabled client in his movement to goals for self-realization; and
      c) coordinates and integrates services of others in the planned process to help the client move to his maximum potential.
   3. Within agency structure, the rehabilitation counselor—
      a) carries out policy and applies standards for services to his client;
      b) assumes responsibility for evaluating the effectiveness of policy and standards in supporting objectives for service to clients; and
      c) stimulates and promotes changes and revisions of policy and standards for improved services through recommendations to administrative personnel.

By way of summary, the training of vocational rehabilitation counselors has become closely identified with the general counselor training programs in operation in our colleges and universities. The Division of Counseling Psychology of A.P.A. and the American Rehabilitation Coun-

seling Association of A.P.G.A. have both published training recommendations for vocational rehabilitation counseling, and the National Rehabilitation Counseling Association of N.R.A. is now in the process of doing so. All three associations recommend a basic core training in psychology, guidance, and counseling with the addition of special courses on rehabilitation followed by a practicum in a rehabilitation setting.

SELECTION, EDUCATION, AND TRAINING OF COUNSELORS WITH DEAF PEOPLE

The foregoing material in this chapter is concerned with the preparation of all counselors who work with disabled persons. This section of the chapter will be concerned with the selection, education, and training of counselors who are to work with people who are deaf. Consideration will be given to the current status of standards in this area, and suggestions will be made concerning desirable training content for counselors preparing to work with deaf people.

Current Training Standards

If a professional investigator unfamiliar with deafness were to be assigned the task of reviewing and analyzing current standards used in the selection, education, and training of counselors with deaf persons, one of the first things he would find is that professional organizations concerned with deafness have no policy statements or certification requirements relating to counselors with deaf people. The Professional Rehabilitation Workers with the Adult Deaf, which is a relatively new national organization composed of various workers with adult deaf people, and the American Instructors of the Deaf, an organization of educators of deaf children and youth, have what might be described as token statements on the subject. However, these statements appear as insignificant when one considers the standards of the A.P.A., the A.P.G.A., and the N.R.C.A.

Historically, educational and rehabilitation services for deaf people have been shrouded in a veil of mystery, at least from the viewpoint of people unfamiliar with deafness. Outsiders have either been generally unaware of the fact that deafness requires special remedial procedures or have assumed that those concerned with deafness are taking care of the problems involved. The first view is illustrated in the many agencies where general counselors are assigned deaf clients, and the latter view is illustrated by the fact that A.P.G.A., A.P.A., and N.R.C.A. have not been

concerned with the special preparation of specialists in the area of deafness.

To an extent education of the deaf has managed to develop teacher selection, education, and training standards, although university teacher-training programs that prepare teachers of the deaf have overemphasized oral teaching methods and have in most cases excluded training in the use of manual communication. The case is far more serious in the area of counseling deaf people, where the field has thus far failed to develop proper training and uniform certification standards.

This situation has resulted in the practice by rehabilitation and education programs for the deaf of employing people on the basis of the agency's philosophy or on the basis of available manpower. In the first case, the quality of the counselor selected is determined by the agency's philosophy, which may be that a general counselor who knows a little fingerspelling or none at all is entirely satisfactory or that a person who knows manual communication but has had no training as a counselor will be able to get the job done.

In the second case, even the best of agencies are forced to settle for an unqualified worker simply because there are not enough qualified counselors with deaf people.

An explanation for the current unsatisfactory state of affairs with respect to uniformity in the preparation and employment of counselors with deaf people may be found in the fact of the relative youth of counseling as a profession. The general field of counseling is, to a great extent, continuing in its quest for an identity as well as uniformity in selection, education, and training standards. The area of counseling deaf people is currently in its early development stages, lagging far behind the general field of counseling and, to an uncomfortable extent, often quite removed from interaction with the parent discipline.

Current Training Approaches

In the general absence of guidelines for the preparation of counselors with deaf people, there have developed four basic types of training approaches. The first of these and, in the authors' judgment, the most desirable, is the university graduate-level program that provides counselor education at the master's and doctoral levels concurrently with specialized coursework in deafness and internship experience with deaf clients.

The second type is the "orientation to deafness" program offered through a university. Such programs are designed to acquaint general counselors with the problems and needs of deaf people and to provide the counselor with basic instruction in manual communication.

The third approach is to provide employed counselors, who may or may not be trained counselors, with on-the-job training relating to working with deaf people. Such training is carried out through seminars, workshops, classes in manual communication, and actual casework experience with deaf people.

The fourth approach is to assign a general counselor to work with deaf clients and expect him to learn about their problems and needs through experience.

A brief evaluation of these four approaches suggests these observations. The graduate training programs find their strength in the core counselor education curriculum and in exposure to supervised casework with deaf clients. The long-term nature of this training ensures basic competence with deaf people. However, there is considerable variation among training programs in terms of training content concerning deafness.

The orientation to deafness programs are brief in nature, covering periods from four weeks to three months. A program of this nature finds its strength in the fact that it can provide basic information on deafness to a relatively large number of trainees. It would seem such programs are of value in acquainting general counselors and agency administrators with the special problems and needs of deaf people. It would seem questionable, however, whether they serve to prepare counselors for *specialization* with the deaf since (1) manual communication skills cannot usually be mastered at the level required for counseling with most deaf people in four weeks to three months, and (2) it is questionable whether adequate practicum experience with deaf clients can be provided in a brief period of time, especially when manual communication is being learned at the same time.

The third and fourth approaches are apparently the least desirable since they are too unstructured and leave too much to chance.

Very capable and effective counselors with deaf people have emerged from each of these four types of training programs, but, it would seem reasonable to conclude that the longer and more rigorous the training, the better qualified the counselor will be.

Specialized Training in Counseling with Deaf People

With this background information in mind, consideration will now be given to the special knowledges and skills the counselor with deaf people should possess. It is here postulated that all counselors with deaf people should have the basic preparation in counseling that is outlined in the first part of this chapter. In the following sections we will be concerned

with the additional requirements in the preparation of counselors for deaf people. This additional preparation falls in two major areas. First, the counselor with the deaf must have didactic and clincial experience in the area of deafness—the nature of the disability and the resulting psychological, social, educational, and vocational handicaps imposed by the disability. Second, he must have adequate preparation in communicating with deaf persons.

Deafness as Disability

The counselor must have sound knowledge of the nature of some important aspects of deafness. This knowledge is needed because it enables the counselor to better understand his individual deaf client's limitations, strengths, and needs and therefore to do a better job of counseling. Knowing these things also is important because the counselor will inevitably be asked by others for sound and reliable information about the nature of deafness.

At times it will be a client himself who requests it, or a family member of a client, the client's employer, or other individuals or agencies that are also working with the counselor's clients or are otherwise concerned about him and want to understand him better. Some of the things the counselor should know are related to the following aspects of deafness.

Etiology. The causes of deafness vary. The counselor must be familiar with some of the more important known causes. If the cause of a client's deafness can be established, certain behavioral patterns probably can be recognized as direct consequences. As a result, the counselor's evaluations of a client's potentials would be more exact, more relevant. Moreover, it increases the likelihood that a counselor's assessment of client functioning will be related to a plan of treatment or training that is best for the client.

Two general causes of deafness are of special concern: deafness due to heredity and deafness due to disease or accident. It is important that the counselor distinguish between these two causes. Hereditary deafness usually may not involve destruction of parts of the brain, particularly in the central nervous system. This means that the genetically deafened person's learning potential is chiefly restricted first by his inability to receive meaningfu' sound through his hearing mechanism and second by his native endowment. Deafness occurring through disease or accident, on the other hand, frequently involves varying degrees of damage to the central nervous system. In this case, the person may also have impairments in memory,

orientation, intellectual functions, judgment, and shallowness and instability of feeling tone. Thus these conditions, when present along with deafness, much more seriously inhibit the deaf person's learning potential.

Some of the more serious and frequently found disabilities that accompany deafness are: mental retardation or deficiency; aphasoid disorders; cerebral palsy; orthopedic defects; emotional disturbance; psychosis; visual and perceptual impairments; epilepsy (Kaufer, 1967; Lawrence and Vescovi, 1967). Evidence that many of these disabilities are associated with four specific etiologies is reported by Vernon (1967b). Vernon found that maternal rubella, Rh factor complications, meningitis, and premature birth accounted for the major share of multiple disabilities among school-age deaf children. In this study, a clear and important distinction between the genetic deaf and multiply disabled deaf was found. In Vernon's words:

> . . . behavior noted as characteristic of deaf children cannot be explained primarily as a reaction to deafness as has been done in the past. It is instead an interaction effect of both the loss of hearing and of other central nervous system pathology associated with the condition causing the deafness. For example, a significant amount of language disability found among deaf children is due in part to organically caused aphasoid disorders, not just deafness. The same is true of other types of learning disabilities. . . . (p. 18)

A major implication from this is that no counselor for the deaf can afford to stop with a medical diagnosis of "deafness" and proceed to base his evaluation, treatment, therapy, or training plans for a client on this diagnosis alone. Experience suggests that this has been done quite frequently in the past and has resulted in grossly unfair and damaging stereotyping of the deaf person by counselors in the field.

Audiology and Otology. All counselors for deaf persons should know the basic terminology and approaches to the measurement of hearing loss used by audiologists and otologists. These specialists use special techniques and equipment that help them distinguish the deaf or acoustically handicapped from other conditions. They may also separate those having a conductive deafness that can be helped by a hearing aid or by surgery from those having nerve damage that can be helped only by special training.

The important consideration is that the counselor for deaf people be able to relate audiological and otological information to the other aspects of deafness with which he is familiar for any given client. This ability is an important difference between the inexperienced, uninformed, naïve counselor and the knowledgeable and discriminative one. The former

counselor will tend to accept readily otological and audiological recommendations that the deaf person be fitted with a hearing aid or be given speech lessons or speech training, and disregard that the client may not want these things or that he may be relatively unable to profit substantially from them. The latter counselor will tend to examine the validity of audiological/otological recommendations in the light of what he knows about the deaf individual's personal preferences, learning ability, educational development, and social and vocational needs and abilities.

The approach of the naïve counselor frequently prevails in those state vocational rehabilitation agencies that have no special counselors for deaf clients. Vescovi (1966) described this practice in these terms:

> Through the lack of time, lack of knowledge of the psycho-dynamic and socio-dynamic plights of individuals disabled by deafness, and because he must make quick decisions, the counselor often is prone to be over-dependent upon "pseudo-experts" on deafness and the deaf. In rural areas the expert may be a traveling county nurse or a hearing-aid dealer. In urban areas it may be an audiologist or otologist with good knowledge of the hard of hearing but not of the deaf. This dependence affects the counselor's judgment, often conditioning him towards forming a preliminary orientation to the deaf referral which will "fit the service to the client" even though that particular service may not be needed.
>
> There also is the danger that the counselor will raise false hopes for the client and his family. The prelingual, profound deaf do not suddenly learn how to speak by taking speech lessons and putting on a hearing-aid in adulthood. (p. 11)

The counselor for the deaf must understand the differences between sensorineural deafness, which refers to hearing losses due to injury or degeneration of the inner ear; conductive deafness, which results from functional deficiencies in the middle ear; central deafness, which stems from malfunction or maldevelopments of central nervous system auditory pathways; and psychogenic deafness, which is a nonorganically involved type of deafness.

With respect to auditory analysis, counselors for the deaf should be expected to understand the information obtained from pure tone audiograms, speech discrimination test audiograms, and the von Bekesy test audiograms. The pure tone test determines whether hearing is normal for pure tones of different frequencies by both bone and air conduction or just how much deficit, if any, exists. Speech discrimination tests are given because the audiometer may not indicate accurately just how well speech will be comprehended. The reading from this test generally agrees with the

audiometric curve for pure tones. The von Bekesy apparatus distinguishes between the sensorineural deafness confined to the cochlea and that in which the difficulty is confined to the eighth nerve.

Psychosocial Aspects of Deafness

The Language Factor. The counselor should be expected to have a thorough understanding of what is without doubt the major and most basic consequence of early deafness: retarded language acquisition.

Although deficient language skills may not account for all of the known psychosocial problems that beset the developing deaf person, it most certainly is related to a great majority of them.

This is because man relates to his culture mainly through his interpersonal interactions with other men, and the vehicle that enables him to do so is language ability. More importantly, language plays a crucial role in man's conception of man. This is cogently illustrated in the following hypothetical situation conceived by Bijou and Baer (1965):

> Suppose you were suddenly confronted with an ape who was perfectly capable of telling you, in good English, his past history, his future plans, and what he claimed were his innermost thoughts and feelings. Suppose further that he were thoroughly competent in carrying on a give and take conversation in practically any subject you choose to discuss. Would you, after such an encounter, treat him as a human being or as an ape? Would you, for example, help him find a comfortable place to live, one in which he might carry on an independent existence, or would you pack him off to the zoo? It would be difficult to decide. (p. 158)

This hypothetical situation neatly encapsulates the historical plight of the deaf: the necessity to struggle eternally to develop proficiency in the language of their culture sufficiently to enable them to enter as equals into the society of man. Levine (1960) poignantly describes the essence of this struggle:

> Not to hear the voice is not to hear spoken language. Not to hear spoken language means that a preverbal child will remain in complete ignorance of this basic verbal tool for human communication and communion unless extra-ordinary measures are taken to teach him that there are such things as words, what words are for, how sounds are combined to form words, how words are combined to form connected language, and how verbal language is applied not only to objects, people, activities, and the like but to all aspects of living, feeling, thinking, and reasoning. Without such highly technical instruction the small profoundly deaf child would be doomed to go through life a completely nonverbal being, unable to enter into

> any verbal communication with others, any verbal deliberation with himself, nor make any significant contact with the knowledge, customs, culture, and climate of the civilization into which he was born. (p. 28)

The insight into the effects of language deprivation upon the deaf child described above point to an inescapable conclusion: without special educational instruction and acceptance and love from his family, guardians, and others who often interact with him, the deaf child cannot grow psychologically. Since all counseling should contribute in some manner to the psychological growth of the person, the counselor working with deaf persons must recognize some of the limitations that language deprivation may impose upon this growth in the deaf child.

First, the deaf child must add information to his store of knowledge by visual means, thus the rate at which he is able to learn is slowed, especially if he has to laboriously build a word vocabulary and cannot readily read and understand written words or words formed on the lips of people.

Second, the deaf child may have a more difficult time in relating new bits of information to old; this makes it hard for him to know what he is expected to do, what action to take, and how to react.

Third, he may have a hard time in making discoveries on his own, i.e., putting facts together so that he recognizes the principles that govern them.

Thus, the deaf child may be cognitively passive in the sense that he tends not to use the manufacturing processes of his brain; his brain therefore is not active enough or independent; he is dependent on other brains for what he should learn and do. What should concern the counselor is that, if this cognitive dependency carries over into the teen years and into adulthood, it may present a special problem, i.e., the deaf person may consider it natural and see nothing wrong with it and may see no reason to change.

Fourth, the deaf child may be overprotected in the sense that his parents and teachers will make too many decisions for him. They may engineer all ambiguity out of the tasks they give him, thus shutting off dissonance and inconsistency in situations. In this way the deaf child may learn falsely that his world is full of absolutes, of black and white, and he may have little tolerance for ambiguity and the strange or unfamiliar.

Fifth, the deaf child may have difficulty in differentiating himself from others, in the sense that he comes to see himself as a unique individual with his own thoughts and feelings and behaviors, and as having the ability to make decisions that do not always have to be validated by

others. This difficulty basically concerns his identity and would be marked by his inability to sufficiently respond to life as an individual.

These two last named elements of psychlogical stifling of the deaf child may be called motivational dependency. If the pattern carries over into adolescence and adulthood the counselor will be confronted by clients who need help in learning to cope with and master an unexpectedly complicated social environment, in developing a healthy self-concept, and in becoming self-directing and responsible individuals.

What the counselor for the deaf should know is whether deaf persons, as a minority group, have at last found or been provided with the means to overcome the language barrier. After 150 years of special education, are deaf adults now integral and productive members of American society or marginal members? Recent research is instructive in answering this question, and all counselors with deaf persons must be familiar with it. The results of some of this research is briefly presented here.

Intellectual Capacities. The distribution of intelligence is the same among the deaf population and the general population (Vernon, 1968); the potential for abstract thought is as prevalent among deaf people as among the hearing (Blanton and Nunnally, 1970; Furth, 1966; Kates, Kates, and Michael, 1962; Lennenberg, 1967; Vernon, 1967c).

Educational Attainment. The average deaf person reaches adulthood grossly undereducated despite his normal potential for language development and abstract thought. The results of several investigations indicate that: 30 percent of deaf children leave school at age 16 or older functionally illiterate; 60 percent leave having achieved at fifth-grade level or below and only five percent attain tenth-grade level; from the age of 10 years to the age of 16 the average gain in reading on standardized achievement tests is eight months; at age 16 the mean reading test score of deaf youth is grade three and four; approximately five percent of deaf youth are able to enter college (Babbidge, 1964; Boatner, 1965; Kohl, 1966; McClure, 1966; Moores and Quigley, 1967; Schein and Bushnaq, 1962; Wrightstone, Aarnow, and Moscowitz, 1962).

Vocational Attainment. The deaf adult is almost universally underemployed. Approximately 75 percent are in skilled or semiskilled occupations while only approximately six percent are in professional and related occupations (Boatner, Stuckless, and Moores, 1964; Dunn, 1957; Justman and Moscowitz, 1963; Kronenberg and Blake, 1966; Lunde and Bigman, 1959; Rainer, Altshuler, and Kallman, 1963; Rogers and Quigley, 1960; Stuckless, 1965).

These investigations suggest that the deaf child has the potential to

learn and to live on equal terms with the non-deaf population but that he has been largely denied the opportunity to do so; the deaf child continues to be psychologically stifled in cognitive and motivational growth. A major effect of such stifling has resulted in the deaf adult who has realized only a fraction of his overall life potentials as reflected in his poor educational and vocational accomplishments. Language retardation, specifically with respect to his inability to adequately read, write, and understand English, has played a prominent role in the deaf adult's relatively marginal participation in American society.

Implications for Counselor Education

We have outlined some critical areas of knowledge with which the counselor for the deaf must be familiar. Now we must ask how does the professional counselor acquire this knowledge? By way of answer, we will illustrate what is being done at the University of Arizona. The university trains professional rehabilitation counselors to work with the deaf. It will be seen that this program provides the counselor-student with both didactic and clinical experiences related to the areas of knowledge we have touched upon in this section.

The University of Arizona Program. The Rehabilitation Counselor with the Deaf Training Program at the University of Arizona, Tucson, Arizona, offers the Master of Science, Ph.D., and Ed.D. degrees in either Rehabilitation Counseling or Administration. A two-year curriculum must be completed to qualify for the master's degree, and an additional two years for a doctorate. This is because of the variety of settings in which the graduate may be expected to work, e.g., educational institutions, community counseling centers, rehabilitation centers and agencies, mental health centers, clinics, etc., and because of the breadth of understanding needed by counselors.

The Arizona program is located in the University's Rehabilitation Center where teaching, research, and service are carried out within three major integrated units: (1) a medical unit, which includes physical therapy, occupational therapy, speech and hearing, medical and audiological consultation; (2) a vocational evaluation unit, which includes work samples, simulated work activities, and psychometric testing; and (3) a special projects unit, which includes community resources development, Veterans Administration counseling, and counseling for alcoholics. The counselor-trainee can expect to spend some time in each unit. He becomes acquainted with the basic philosophy and practice of occupational therapy, physical therapy, speech and hearing, medical consultation, psycho-

logical evaluation, vocational evaluation, and related services. Furthermore, he may be expected to participate by serving as an aide to the various therapists, by administering psychological tests, by writing reports, and by taking part in case staffings and staff seminars.

The counselor-trainee takes special courses that expose him to the specialized knowledge of deafness that he must have. For example, in special seminars on deafness and in courses on rehabilitation of the deaf, a concentrated effort is made to identify and assess the etiological, otological, audiological, and language factors as they relate to counseling theory and practice. The counselor-trainee then has the opportunity to apply this knowledge in special practicum situations. He works with deaf children in the Arizona State School for the Deaf and Blind, and with children and deaf adults receiving services in various special schools, clinics, hospitals, correctional institutions, the Department of Vocational Rehabilitation, and adult education programs in the Tucson area.

Another major aspect of the practicum experiences is that they provide the counselor-trainee with opportunities to sharpen communication skills with deaf persons. By interacting with deaf children and deaf adults, at their individual levels of communication skills, the counselor also learns of the strengths and limitations of such communication modes as sign language, fingerspelling, gestures, lipreading, speech, and writing.

Counselor-trainees in the Arizona program are also given the opportunity to counsel non-deaf clients. It is felt that this exposure to non-deaf client counseling gives the student added insights into the different communication and language problems that exist among deaf clients. This also is required of the student who himself may be deaf.

All counselor-trainees at the University of Arizona must go through an internship. This usually takes place at the end of their course work. It involves a minimum of three months on the job in an agency or program that specializes in services to deaf persons. Whereas the supervised practicum experience has as its major objective the development of counselor skills, e.g., the application of counseling techniques per se, the internship, on the other hand, is designed to help the student integrate these various principles and techniques into a broad and meaningful role as a counselor for deaf persons. It is felt that the student who is provided a good basic education, accompanied by a liberal and varied sequence of clinical experience will be in a favorable position to adapt himself to the other role requirements of the job into which he finally steps. Examples of internship sites, which may be used by the University of Arizona program, are: state divisions of vocational rehabilitation in Arizona, Missouri,

Michigan, Massachusetts, and Texas; Gallaudet College; National Technical Institute for the Deaf; Arkansas Rehabilitation Center; Seattle Rehabilitation Center for the Deaf; Kansas City Community Counseling Center for the Deaf; St. Louis Jewish Rehabilitation Workshop; and Goodwill Industries of Cleveland, Ohio.

Communicating with Deaf People

Where the general professional counselor would be expected to have a better than average knowledge of various methods of communication and a better than average ability to use these methods effectively with his clients, it is vital that the professional counselor for deaf persons be exceptionally proficient in both respects.

In the first instance the counselor must have reliable knowledge about the communication methods used by the deaf because this information is valued by other people who are involved with the deaf person, e.g., parents and family members, employers, and other professional workers. This is in recognition of the fact that the counseling process and outcome are not always determined by a simple series of contacts between two isolates, the counselor and the client (Olshansky and Margolin, 1963). Hence the counselor must often share his knowledge with others who may have a claim on the client or who are otherwise interested in his welfare. Not to be able to do this sharing may create peripheral conflicts that damage the counselor's relationship with his clients. And where a poor relationship exists between the counselor and the client constructive counseling is not possible.

In the second instance, there are several reasons why the counselor of deaf persons must be skilled and versatile in communicating with deaf individuals. The chief reason is that the deaf person himself, like other clients, is the most important and reliable source of information about himself, i.e., of his needs, values, aspirations, and perceptions of problems important to him. By not being able to communicate with the deaf person, the counselor is denying him the right to represent himself in his own way and on his own experiential level. This denial too often results in enforced counselor manipulation of the client, alienation of the client, and an outcome that has little relation to the client's needs. Vescovi (1966) focused on this problem in these words:

> Even the more conscientious counselor upon recognizing that he has not been understood is apt to bypass the deaf client altogether in favor of communicating with the client's family, his friend, the local expert on the deaf, and even the client's neighbors. Thus . . . many

> deaf are repelled and do not "cooperate." Others, similarly treated, "go along" because they have no choice. (p. 10)

Second, too often the deaf client's own family cannot communicate with him. The counselor who is himself skilled in communication may teach them to do so. With respect to helping the client become less isolated and more accepted by his own family, and vice versa, the counselor's intervention is fully justified. Indeed, the ability to intervene competently in this manner should be routinely expected of all counselors of deaf persons. This skill is especially pertinent with respect to counselors who are in contact with deaf children, deaf teenagers, and their families.

Third, it has been amply documented in the literature on deafness, e.g., Best (1943) and Levine (1960), that the deaf are, first of all, people, and therefore individuals with varied personal attributes, and that the ability of the deaf to communicate also is extremely varied. Furthermore, a sine qua non in all counseling is that the counselee be treated as a unique individual (Carkhuff and Truax, 1967; Patterson, 1966; Rogers, 1957; Tyler, 1959, 1960). If the deaf are to be treated as people and as individuals the counselor must be able to communicate in the vari ways used by them. This is no easy task. Levine (1960) in describing the varied language and communication abilities of the deaf, shows just how difficult communicating with the deaf can be:

> There are those who can speak and read lips with amazing skill, others who can speak but have difficulty in reading lips, still others who can read lips but who cannot speak comprehensibly, and some who can do neither but rely entirely upon writing and/or manual communication. . . . There are those whose oral skills are inferior but whose language skills are unusual; conversely, there are others whose impoverished supply of language is used with exceptional clarity in oral expression. (p. 47)

Communication Methods and Problems in Counseling

A philosophical discussion on the merits of the different communication methods in use by the deaf is not relevant to this chapter. All the methods discussed here have their good and bad points. The important issue is that deaf individuals do use these methods and, regardless of the extent that deaf people as a group may use any one of them, the counselor must be able to understand them all and to apply them himself, as needed, with any deaf individual. With this in mind, we will address ourselves to a brief examination of each method, focusing on the problems they create that may be pertinent to the counseling relationship.

Expressive Communication Methods. Expressive methods open to the deaf client are either manual or oral. If manual, he may use, either predominantly, alone or simultaneously, body gestures and facial movements; fingerspelling; sign language; writing. If oral, he uses speech.

With deaf clients who use manual methods the counselor "listens" visually, that is, he is dependent upon his vision for communications coming from his client. To be an effective visual *listener* the counselor must have technical visual listening skills, i.e., he must be familiar with the structures associated with each manual method, and he must be able to concentrate visually sufficient to receive them. Furthermore, to be an effective visual *observer* the counselor must be able to interpret the incoming "manualisms" for relevant meaning. For example:

> A client's shrug of his shoulders accompanied by a bland facial expression may be interpreted as "It doesn't make any difference" or "So what!?" whereas a shrug of the shoulders accompanied by a facial wince and an almost imperceptible movement of the head may be the client's way of saying, "I don't understand you," "What did you mean, please repeat what you said," or "Come again?" (Body movement and facial gestures).
>
> A client may write ungrammatically "Father me vacation year last," which may be a clear thought expressed awkwardly, i.e., "My father and I went on vacation last year." (Writing).
>
> A client may make three signs, the signs for "late," "eat," and "me" and present them to the counselor in that order so that if the counselor is technically familiar with the meaning of each sign he still must interpret the idiom in the order presented: "Late—eat—me." Translated, the client is saying "I haven't eaten yet." (Sign language idiom).
>
> The client may fingerspell words that are not complete—some letters may be missing—and the counselor must be unusually attentive if he is to fill in the missing elements. When this occurs it usually approximates the following pattern: The client may spell the correct first, second, and third letter of a word, leave out the next few middle letters (or just flick his fingers up and down rapidly to indicate that he doesn't know the correct letters that go into the middle) and end by correctly spelling out the last two or three letters. (Fingerspelling).

From these examples it is evident that, while it is difficult enough for the counselor to understand and interpret one manual method, it is much more difficult for him to interpret and understand several methods when they are used simultaneously by the same client (as often happens!). Hence, the basis for the occurrence of miscommunication between the counselor and his deaf client is a broad one.

With deaf clients who use speech as their predominant expressive method, the counselor is auditorially oriented. If the deaf client articulates clearly and distinctly, there is little that interferes with the reception of incoming client verbalizations. When the speech of the deaf client is not clear and, in fact, does not clearly enough approximate the level of normal speech to which the counselor is habitually responsive, then he must make an extra effort to "tune in" on the client's imperfect speech pattern. As an aid to understanding, the counselor must often lipread his deaf client—the sound that emanates from the deaf client's vocal apparatus may bear little resemblance to consonants, vowels, or words, but the deaf client's lip-movements may approximate them and therefore may be understood somewhat.

In any case, the counselor is forced to deviate from his accustomed habits of listening and looking and, in effect, is required to become adept in speech discrimination as well as lipreading. It is obvious that the need to do these things, at least with "speech only" oriented deaf clients, greatly inhibits the counselor and greatly sterilizes the interaction between the counselor and his client.

With deaf clients who use poor speech in combination with one or more of the manual methods, the counselor may actually have to try to ignore the client's discordant and garbled vocal sounds in an effort to understand and interpret his manual transmissions. It is clear that the counselor's acquisition of this ability (and it is an ability of dubious worth if the counselor cannot understand manual communication either) is done in self-defense, i.e., he must retain some vestige of control over a counseling situation that is on the brink of chaos.

An important implication from the above is that the counselor must adapt himself to the expressive communication methods of the deaf client. The alternative is to force the deaf client to adapt himself to the counselor's receptive methods of communication, i.e., to speak clearly and grammatically in English so that the counselor can hear comfortably; to write clearly and grammatically in English so that the counselor can use his reading skills without strain; to refrain from using fingerspelling, sign language, or body gestures so that the counselor may retain his social equilibrium while counseling. To accept this alternative is to accept these conditions. To accept these conditions is to deny the deaf child and deaf adult his right to be himself fully by communicating in the only ways he knows and that are most natural to him. To accept this alternative is also to eliminate the possibility that the deaf person will benefit more than superficially from counseling. Whereas the counselor can learn, admittedly

with some pain, to adapt himself to the deaf person's expressive communication methods without losing his identity, the deaf person cannot adapt himself to the counselor's receptive communication methods without losing his.

If only a few deaf people were deficient in written English and speech skills and if only a few deaf people used body movements, gestures, sign language, and fingerspelling, it would probably be unrealistic for us to ask that counselors develop special communication skills to work with these few deaf people. The facts, however, are that the incidence of prelingually deafened people who have not developed intelligible speech is high (Levine, 1960; Vernon, 1969b), and the use of manual communication among the deaf is common (Quigley, 1963; Lunde and Bigman, 1959; Levine, 1960). Hence the need for counselors who are flexible in communicating with the deaf is acute.

Receptive Communication Methods. The deaf person may receive communications both auditorially or visually. Auditorially, he relies on his hearing aid chiefly to bring him sounds from his environment. A hearing aid cannot bring him words from non-deaf people who speak to him. If visually, he relies on his eyes to bring him the information he needs. This means he must use his eyes to read lips, to read printed matter, to read signs and fingerspelling, body movements and facial gestures, and "read" the signs given by situations and events in his environment. Quigley (1963) clearly expresses this visual dependency:

> while most deaf persons have some small amount of residual hearing, this usually is of limited value for communication purposes. Such people are essentially linked to the world with their eyes. Vision is the channel through which they receive information about their environment. They receive this information in the form of reading—reading lips, reading the printed word, or reading manual communication in the form of signs and fingerspelling. What hearing they have can often be utilized to supplement vision—but only to supplement it, never to replace it as the primary sense modality. (p. 2)

It is clear, therefore, that the counselor must be able to express himself to his deaf client using essentially manual forms of communication, but stressing sign language and fingerspelling. Some of the inevitable problems that face the counselor who must communicate manually are briefly described here.

Sign Language. All counselors of deaf persons must realize that the sign language *is* a language in itself and not merely the English language reproduced graphically. In order to think clearly and logically deaf per-

sons are not required to first learn the English language (Furth, 1966; Tervoort, 1970). The language of signs has an orderly structure even though this structure does not parallel that of English. For example, a client who signs, "Me movie yesterday go" is expressing the same thought that one would express in good English by saying, "I went to the movies yesterday." Although somewhat oversimplified, this example suffices to point out that the counselor must be able to express himself to his deaf client in sign language structure if he expects to be readily understood. Furthermore, the counselor need not feel duty-bound to use signs along the English grammatical pattern.

Fingerspelling. With most deaf clients the counselor must use fingerspelling as a supplement to sign language. This will usually occur when the counselor needs to use nouns, e.g., the names of people, places, companies, and the like. When used as a supplement, fingerspelled words fit into the structure of sign language without destroying it.

Writing. Given their weakness in reading English constructions, deaf persons are not likely to understand clearly the counselor who conveys messages in this manner. The best use of writing in the counseling situation is when its use is restricted to descriptive messages from the counselor. For example, giving directions, describing the location of a job and its work schedule, or outlining definite tasks that the client is expected to accomplish. It is naïve to expect that those aspects of counseling which are related to therapy, e.g., discussions of client anxiety or the development of healthy self-attitudes, etc., will lend themselves to solutions solely on the strength of written messages from the counselor.

Body Gestures and Facial Cues. The chief value of these forms of communication lies in their ability to add clarity and meaning to sign language and fingerspelling. They often are equivalents to English adjectives and adverbs in that they modify and emphasize the magnitude, intensity, duration, and frequency of experiences. For example, one may say in sign language only, "I was very sick." This does not tell the listener how sick the person was. However, if one were to grit his teeth and hunch his shoulders while touching his forehead and stomach (the sign for sick) a feeling for the intensity of his illness would be conveyed.

Speech Reading (Lipreading). The counselor for the deaf may find that some of his deaf clients may be able to apprehend many of his lip-movements, but this does not mean that correct interpretation of the lip-movements automatically follows. We are constantly and relevantly reminded by the literature that 40 to 60 percent of the sounds of the English language are homophenous, i.e., they look just like some other sound

on the lips. Another limitation in speech reading is that even the good lipreader can be distracted by a number of factors, i.e., poor lighting, small immobile mouths, head movements, fatigue, etc. These conditions reduce the percentage of most speech that can be read to approximately 30 percent (Lowell, 1959). For those deaf persons less proficient in lipreading, and there are many, the percentage of speech that can be lipread is much less than 30 percent.

The important point being made is that the counselor for the deaf should not assume that because his words sound clear to him they are being clearly formed on the lips. This is frequently not happening. If speech reading is the chief receptive method used by a deaf client, the counselor must frequently obtain feedback from the client to make sure he has been communicating. For most deaf clients speech reading is of value only as a supplement to manual communication.

In summarizing this section on communication methods we must emphasize the salient ideas with respect to the counselor for deaf people and communication ability. These ideas are that: (1) the deaf person must be allowed to communicate with the method that is most natural, comfortable, and effective *to him;* (2) therefore the counselor should be proficient in all methods that are relevant to the deaf. The major implication of these two central ideas is that all counselor for the deaf training programs have the responsibility to provide counselor trainees with classroom and situational experience in communicating with deaf individuals. Examples from the University of Arizona program may illustrate how this is being done at the present.

University of Arizona. The Rehabilitation Counselor Training Program at the University of Arizona requires that students acquire a sound knowledge of the various communication methods of the deaf and develop effectiveness in using them. To help reach these objectives both classroom instruction and practical experiences are offered. Some of these classroom and practical experiences are described below.

"Manual Communication." The development of expressive and receptive skills in fingerspelling, sign language, pantomime, and natural gestures is stressed. This class is taught by instructors who have had extensive educational and rehabilitative experience with and among the deaf. Counselor-students not only practice the techniques with each other, but with deaf adults from the community who attend the sessions for this purpose. Special emphasis is placed on the development of counselor-student *receptive* manual skills since its acquisition is much more difficult than is the acquisition of expressive manual skill.

"Speech." This course is especially useful for counselor-students with minimal familiarity with habilitative and rehabilitative aspects of deafness. It covers the role of speech, hearing, and language in human communication. While communicative disorders are covered, primary emphasis is placed on the normative aspects of speech, hearing, and language.

"Audiology." This course is specific to rehabilitative aspects of the deaf and hard of hearing. Emphasis is on pathologies of the hearing mechanism and their auditory manifestations, evaluation and applications of audiological diagnostic procedures, and treatment aspects, e.g., aural (hearing aid) training and speech-reading skill development.

"Rehabilitation of the Adult Deaf." This course includes an in-depth study of all communication methods used by the deaf, manual and oral. An overview of research and literature pertaining to communication among the deaf is made. Special emphasis is placed on the examination of the relationships between manual and oral skills and social, mental, emotional, educational, vocational, and family adjustment.

"Observation and Participation." This course is designed to give the counselor-student opportunity to observe and participate in the work of professionals actually working with the deaf child and deaf adult. The counselor-student will observe the communicative interactions of audiologists, otologists, speech therapists, vocational rehabilitation counselors, vocational evaluators, and others with their deaf clients. For example, the speech therapist, audiologist, and a vocational evaluator in the University of Arizona Rehabilitation Center use manual methods of communication when needed with their deaf clients. The counselor-student is in an excellent position to compare the effectiveness of these specialists who can communicate more readily with the deaf with those who cannot.

"Practicum." It has been mentioned previously in this chapter that the counselor-student in the University of Arizona program learns to communicate with deaf individuals by actually counseling them and that he is given ample opportunity to do this. To repeat briefly, professionally supervised individual and group counseling is available to the counselor-student at the Rehabilitation Center and at the Arizona School for the Deaf and Blind. All that can be added here is that all counselor-students are encouraged to meet and mingle with the adult deaf in the community, e.g., visit their clubs, their homes. To join them in their individual and group activities is the only way to learn to communicate effectively with them, and relevant communication is a prerequisite for understanding them, which all professional counselors must do before they can counsel the deaf.

Additional Aspects of Training

In addition to the two main areas of special preparation, there are some other aspects of the preparation of counselors of deaf people that deserve attention. The first is in the area of community relations and the second is in the area of psychological testing.

Community Relations. The likelihood that a counselor for the deaf will function solely as a psychological counselor is remote. This will be the case for counselors in Division of Vocational Rehabilitation agencies for the most part (Tully, 1970) and *very probably* the case for counselors in other settings. The chief reason for this is that the counselor, in addition to his counseling of individual clients, will be expected to keep records, write reports, attend staff meetings, and so on. In a sentence, the counselor must have some administrative ability.

Although all counselors for the deaf must have this administrative training, it does not distinguish them from any professional counselor who also must have it. What does make the counselor for the deaf stand out is that he may be one of a very few people in the community who is an authentic expert on deafness and deaf people. When this is the case, it is the counselor's responsibility to share his expertise not only with his clients, the client's family, or others who have a claim on the client, but also with the general community. In effect, the counselor must work for community understanding and acceptance of deaf people as a group. For example, he must work with agencies or groups controlled by deaf persons themselves and with other agencies and organizations that are in contact with and purport to serve deaf people in some manner.

In order for the counselor to intervene actively and specifically in what usually will be complex and broad community situations he must be skilled in interpersonal relations. Basically this requires that he understand, accept, and work within the limitations of other people, especially with respect to what people in any given community do not know or understand about deafness and deaf people.

Besides giving counselor-students a thorough understanding of the facts related to the abilities and capacities of deaf people and their limitations, all counselor-for-the-deaf training programs should also give the counselor-student the skill to interpret and present this relevant knowledge to the community without alienating that community.

Psychological Testing. The professional counselor for the deaf is expected to be as technically skillful as any professional counselor with respect to understanding, administering, and interpreting test results. Only by having this technical skill can the counselor begin to understand why

certain tests may or may not be used fruitfully with deaf children and adults. No counselor-training program should eliminate this requirement because of the oft repeated ideas that (1) few tests have been constructed that can be used solely with deaf persons; (2) most tests are designed to measure various traits or attributes of sense-intact persons and so are verbally loaded and cannot work with language-impoverished deaf people; (3) special knowledge of deafness, deaf people, and their community and language problems provides a counselor with special insight that precludes the need for testing skill.

Certainly, it is a well-known fact that few tests have been fashioned for exclusive use with the deaf. There should be no refutation of this. However, more of such tests could and should be developed. The people most likely to do this are those who have sound knowledge of the language and communication strengths and weaknesses of the deaf *and* a thorough understanding of general test construction, administration, and interpretation principles. The counselor for the deaf should be expected to be one of these people.

It also is true that most tests are verbally oriented and therefore their indiscriminate use with deaf persons can be damaging. But, it is also true that some of these tests, if used judiciously and with understanding of the needs of the deaf client, can be very useful (Brenner and Thompson, 1967; Falberg, 1967; Vernon, 1967a).

While it may be true that in some instances counselors who have acquired sound knowledge of deafness and deaf people also have acquired special insight about them, it is naïve to believe that this insight renders testing skill irrelevant. Testing skills, used judiciously with selected tests, can enhance this insight and, in many cases, validate it since tests are constructed to yield objective information about the person tested.

Counselors should be familiar with several important implications that have emerged from that body of research which has focused on assessment of the "deaf personality." For example, Donoghue (1970) in his overview of this research, has clearly shown the limitations of the projective tests used in these investigations—Minnesota Multiphasic Personality Inventory, Rorschach, Thematic Apperception . . . :

> . . . the results attained to date in research may not be presenting a valid picture of this (deaf) subculture's personality structure. Possibly part of the onus of these findings can be laid at the door of the tests themselves. As was indicated, projective tests have never been fully validated and objectively tested for reliability. What statistical procedures have been used in an effort to provide something more solid than an examiner's sometimes nebulous clinical judgments are

still but records of subjective interpretations, and hence, only slightly more useful. (p. 6)

With respect to the special attributes needed by those who test deaf people, Donogue (1970) has underscored the importance of counselor-communication proficiency in this particular area:

> The competent tester should possess at least two attributes primarily: (1) he should be well versed in all communication techniques utilized by the deaf person he tests. By this, it is also implied that the limitation of each of these techniques should be recognized and accounted for. As an example, some of the research using the Rorschach while depending on speechreading ignored that the best of lipreaders understand but 25% of what is said. Obviously, failing to acknowledge this belies the illusion of competent testing; (2) the tester should be able to identify closely with the deaf, i.e., exhibit some degree of empathy. (p. 6)

In Conclusion

In this section we have tried to describe in some detail some of the qualifications and standards that should be required of all counselors who work with deaf persons. It should not be thought that the qualifications and standards mentioned here are all that is needed to ensure professional competence. There may be others that are unknown to or overlooked by the writer. The suggestions in this section should instead be thought of as a preliminary overview of what we believe to be some of the most basic qualifications and standards for counselors who work with deaf people.

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